Elsbeth Martindale, Psy.D.

5525 E. Burnside
Portland, OR 97215
Phone (503) 236-0855 FAX (503) 406-2448

Welcome!

As on January, 2023, I have shifted into a semi-retirement phase. I'm only working two days each week, spending the rest of my time writing, developing trainings, and, of course, relaxing!

I have availability for a small handful of clients as well as group work. If you are looking at these forms you are either a returning client, a therapist, or a brand new client who somehow convinced me to take you on. I assume we have talked and have made some preliminary agreements to work together. If we have not spoken please call my office before preceding with these forms.

I am no longer on any insurance panels. If you wish to use insurance to cover your sessions with me you will need to request a superbill to submit to your insurance provider. You will be responsible to pay in full for each session at the time of service.

Please return the following:

- ❑ HIPPA Form
- ❑ Informed Consent for Treatment
- ❑ Client Information Questionnaire
- ❑ Current Symptoms

My office is in an old Victorian Home on East Burnside. This is a busy street. I suggest you park on a side street and walk. You may park in front of the house except for the hours of 7:00 and 9:00 AM.

If you need wheelchair access, please let me know this in advance. I have a ramp, in the back of the office, for those who may have difficulties with stairs. Please tell me about your access needs so I can make necessary accommodates.

I look forward to working together soon.

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HIPPA: ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment.

I understand and agree that Dr. Martindale, and her staff, may use and disclose health information about me. I understand that my health information may include information created and received by Dr. Martindale, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, prescriptions, and similar types of health-related information.

This information may be used and disclosed in order to:

- make decisions about and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care
- perform various office, administrative and business functions that support Dr. Martindale's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective health care.

I understand I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy information sheet, and I understand Dr. Martindale is not required by law to agree to such requests.

By signing below, I acknowledge I have received, reviewed, understand, and agree to the information above and in the Notice of Privacy.

_____ _____

Signature of Client Date Signed

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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 503-406-2448.

Client's Initials _____

FEES/ ADDITIONAL CHARGES/ BILLINGS/ OFFICE POLICIES PROFESSIONAL FEES

My fees are based on the amount of professional time spent or reserved. Psychotherapy is charges at the rate of $175 per clinical hour (45 minutes). Sliding scale options are available upon request and can go as low as $150 per hour. Group psychotherapy (90 -120 min.) is $80 a session. Additional time for phone calls, preparing letters, conferring with other professionals, etc. will be prorated at $180/hour. 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.
- $150 should you fail to keep an appointment and fail to give us 24 hours advance notice that you will not keep such appointment.

BILLINGS - You are required to pay in full for services. If you plan to bill insurance, you may request a superbill that you can submit to your insurance carrier for reimbursement to you directly.

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. My voice mail is accessible at all hours. You will be charged $150 for any missed session without a 24 hour notice.

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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Please complete the following questionnaire which will be helpful in planning our services for you. If you need any clarification, please do not hesitate to call my office.

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 _____

Spouse's Name: _____

Spouse's Employer: _____

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

Name	Age	Relationship	Occupation

Who suggested you contact me? _____

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 _____

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

_____

_____

List any medications you are currently taking:

Name of medication	Purpose	Dose & Frequency	Start Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Briefly describe your 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 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? _____

_____

_____

_____

_____