

**NEW CLIENT FORM**

***Aaron K. Potratz, LPC MA CADCI***

12250 SW 2<sup>nd</sup> St., Suite A-103

Beaverton, OR 97005

(971) 222-8166

**Date:** \_\_\_\_\_

**Name (First, Middle Initial, Last):** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Work:** \_\_\_\_\_ **Cell:** \_\_\_\_\_

**Is it okay to leave a message at any of the above numbers? Y / N Which?** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Sex:** Male / Female

**Marital Status:** \_\_\_\_\_

**Employment / Student Status:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_

**FAMILY BACKGROUND INFORMATION**

***Aaron K. Potratz, LPC MA CADC-I***

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Your First Name: _____	MI: _____	Last Name: _____
Birth Date: _____	Age: _____	
Street Address: _____	City: _____	State: _____
Zip: _____	Home Phone #: _____	OK to leave message? Yes / No
Alternate Phone #: _____	OK to leave message? Yes / No	
Occupation: _____	Time At Job: _____	
Last Academic Level Completed: _____		
Religious Preference: _____		

Partner's First Name: _____	MI: _____	Last Name: _____
Birth Date: _____	Age: _____	
Street Address: _____	City: _____	State: _____
Zip: _____	Home Phone #: _____	OK to leave message? Yes / No
Alternate Phone #: _____	OK to leave message? Yes / No	
Occupation: _____	Time At Job: _____	
Last Academic Level Completed: _____		
Religious Preference: _____		

**Marital Status (check one):** Single \_\_\_ Married \_\_\_ Separated \_\_\_ Divorced \_\_\_ Widowed \_\_\_

**# of Years Married:** \_\_\_\_\_ **# of Previous Marriages:** Husband \_\_\_\_\_ Wife \_\_\_\_\_

## FAMILY BACKGROUND INFORMATION

**List the Name, Sex, Birth Date, and Age of each child presently *living in* the home:**

Full Name	Sex	Birth Date	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please complete the same information for any children living *outside* the home:**

Full Name	Sex	Birth Date	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Please list the name and relationship of any others living in the home:**

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____

**Have you or any member of your immediate family had any previous counseling? Yes / No**

If so, approximate dates of previous counseling: From \_\_\_\_\_ to \_\_\_\_\_

Please briefly explain the nature of that counseling:

**Have you or any member of your immediate family ever seriously considered or attempted suicide?**

Yes / No      If so, please explain:

**Have you or any member of your family ever been hospitalized for a mental health condition?**

Yes / No      If so, please give dates and briefly explain:

## FAMILY BACKGROUND INFORMATION

**When was the last time you drank an alcoholic beverage:** Date \_\_\_\_\_ Amount: \_\_\_\_\_

**How many drinks do you consume per week on average?** \_\_\_\_\_

**Have you or your partner ever used illegal drugs?** Yes / No

If so, please explain and give dates:

**Are you presently, or have you ever been concerned about you or your partner's drinking or drug use?** Yes / No

If so, please explain:

**Have you or your partner ever been arrested or convicted of a crime (other than parking or speeding tickets)?** Yes / No

If so, please explain and give dates:

**Do you or any member of your family have a medical condition in which you are under the care of a doctor?** Yes / No

If so, please explain:

**Please list any medications you or members of your immediate family are currently taking, including dosage:**

## PROBLEM CHECKLIST

Name \_\_\_\_\_

### PROBLEM CHECK LIST (Check all that apply)

ISSUE	PAST PROBLEM	PRESENT PROBLEM
Physical Problem: _____	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Eating	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Problem	<input type="checkbox"/>	<input type="checkbox"/>
Performance at School	<input type="checkbox"/>	<input type="checkbox"/>
Performance at Home	<input type="checkbox"/>	<input type="checkbox"/>
Performance at Work	<input type="checkbox"/>	<input type="checkbox"/>
Making Friends	<input type="checkbox"/>	<input type="checkbox"/>
Understanding Others	<input type="checkbox"/>	<input type="checkbox"/>
Shyness	<input type="checkbox"/>	<input type="checkbox"/>
Feeling Victimized	<input type="checkbox"/>	<input type="checkbox"/>
Feeling Rejected	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Have a Good Time	<input type="checkbox"/>	<input type="checkbox"/>
Feel Cut off from Others	<input type="checkbox"/>	<input type="checkbox"/>
Communication Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Problem	<input type="checkbox"/>	<input type="checkbox"/>
Financial Problem	<input type="checkbox"/>	<input type="checkbox"/>
Fear of: _____	<input type="checkbox"/>	<input type="checkbox"/>
Can't Stop Thinking About: _____	<input type="checkbox"/>	<input type="checkbox"/>
Feel Depressed	<input type="checkbox"/>	<input type="checkbox"/>
Feel Inferior	<input type="checkbox"/>	<input type="checkbox"/>
Emotionally Numb	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Confidence	<input type="checkbox"/>	<input type="checkbox"/>
Excessive Worrying	<input type="checkbox"/>	<input type="checkbox"/>
Can't Make Decisions	<input type="checkbox"/>	<input type="checkbox"/>
Don't Like Weekends or Vacations	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Lack of Goals	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Cope With Day to Day Life	<input type="checkbox"/>	<input type="checkbox"/>
Afraid of Being on My Own	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal Thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Feeling Tense	<input type="checkbox"/>	<input type="checkbox"/>
Feeling Anxious	<input type="checkbox"/>	<input type="checkbox"/>
Feeling Angry	<input type="checkbox"/>	<input type="checkbox"/>
Physical Violence	<input type="checkbox"/>	<input type="checkbox"/>
Can't Sit Still	<input type="checkbox"/>	<input type="checkbox"/>
Over-Ambitious	<input type="checkbox"/>	<input type="checkbox"/>
Unable to Relax	<input type="checkbox"/>	<input type="checkbox"/>
Seeing or Hearing Things	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Affairs (emotional, sexual)	<input type="checkbox"/>	<input type="checkbox"/>
Addiction : substance (alcohol, marijuana, nicotine, etc), food, sex, shopping, gambling	<input type="checkbox"/>	<input type="checkbox"/>

Additional Comments:

## COUNSELING SERVICES INFORMATIONAL CONTRACT

***Aaron K. Potratz, LPC MA CADC-I***

12250 SW 2<sup>nd</sup> St., Suite A-103

Beaverton, OR 97005

(971) 222-8166

This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

### **PSYCHOLOGICAL SERVICES**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the counselor and client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

### **MEETINGS**

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50

## **COUNSELING SERVICES INFORMATIONAL CONTRACT**

minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24-hours advance notice of cancellation, unless we both agree that you were unable to attend due to circumstances beyond your control (for example, roads were icy and it would have been dangerous for you to attempt to drive to the appointment location). If it is possible, I will try to find another time to reschedule the appointment.

You normally will be the one who decides therapy will end, with three exceptions. If we have contracted for a specific short-term piece of work, we will finish therapy at the end of that contract. If I am not, in my judgment, able to help you because of the kind of problem you have or because my training and skills are, in my judgment, not appropriate, I will inform you of this fact and refer you to another therapist who may meet your needs. If you do violence to, threaten, verbally or physically, or harass myself, the office, or my family, I reserve the right to terminate you unilaterally and immediately from treatment. If I terminate you from therapy, I will offer you referrals to other sources of care, but cannot guarantee that they will accept you for therapy.

### **PROFESSIONAL FEES**

My hourly fee is \$100 for 50-minute sessions. In addition to weekly appointments, I charge these amounts for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour or prorate mutually agreed upon extended sessions based on the hourly rate. Other services include report writing, telephone or electronic conversations lasting longer than 5 minutes in a week, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge \$150 per hour for preparation and attendance at any legal proceeding.

### **BILLING AND PAYMENTS**

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.

## **COUNSELING SERVICES INFORMATIONAL CONTRACT**

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and the amount due.

### **DIAGNOSIS**

If a third party such as an insurance company is paying for part of your bill, I am normally required to give a diagnosis to that third party in order to be paid. Diagnoses are technical terms that describe the nature of your problems and something about whether they are short-term or long-term problems. If I do use a diagnosis, I will discuss it with you. All of the diagnoses come from a book titled the *DSM-IV TR*; I have a copy and will be glad to let you borrow it and learn more about what it says about your diagnosis.

### **INSURANCE REIMBURSEMENT**

I am not currently accepting insurance at this time. I can provide receipts for sessions that include information that you may submit to your insurance company; however, reimbursement is not guaranteed and depends on many factors such as your deductible, copay/coinsurance, and coverage.

### **CONTACTING ME**

I am often not immediately available by telephone. While I am usually in my office weekdays between 12 PM and 8 PM, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call you may contact your family physician, the Washington County Crisis line at (503) 291-9111, or call 911 if it is an emergency. If I will be unavailable for an extended time, I will inform you ahead of time and provide you with the name of a colleague to contact, if necessary.

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### **PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. Under the provisions of the Health Care Information Act of 1992, you are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any time spent in preparing information requests.

### **MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

### **CONFIDENTIALITY**

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

**There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment.**

1. If I believe that a child, elderly person, or disabled person is being abused, I may legally break confidentiality to file a report with the appropriate state agency.

## COUNSELING SERVICES INFORMATIONAL CONTRACT

2. If I believe that you are in imminent danger or harming yourself, I may legally break confidentiality and call the police or the county crisis team. I am not obligated to do this, and would explore all other options with you before I took this step. If at that point you were unwilling to take steps to guarantee your safety, I may then be obligated to seek hospitalization for you or to contact family members or others who can help provide protection.
  
3. If I believe that a client is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

You are also protected under the provisions of the Federal Health Insurance Portability and Accountability Act (HIPAA). This law insures the confidentiality of all electronic transmission of information about you. Whenever I transmit information about you electronically (for example, sending bills or faxing information), it will be done with special safeguards to insure confidentiality.

## COUNSELING SERVICES INFORMATIONAL CONTRACT

If you elect to communicate with me by email at some point in our work together, please be aware that emails is not completely confidential. All emails are retained in the logs of your or my internet service provider (ISP). While under normal circumstances no one looks at these logs, they are, in theory, available to be read by the system administrator(s) of the internet service provider. Any email I receive from you, and any responses that I send to you, will be printed out and kept in your treatment record.

**The next is not a legal exception to your confidentiality. However, it is a policy you should be aware of if you are in *couples therapy* with me.**

If you and your partner decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. *Do not tell me anything you wish kept secret from your partner.* I will remind you of this policy before beginning such individual sessions.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Other(s) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PROFESSIONAL DISCLOSURE STATEMENT

***Aaron K. Potratz, LPC MA CADC-I***

12250 SW 2<sup>nd</sup> St., Suite A-103

Beaverton, OR 97005

(971) 222-8166

**Philosophy & Approach:** I believe that counseling is a process to provide insight and understanding in order to improve your life. It is my desire to join with you as a collaborative team, cooperatively setting and working towards counseling goals. While I may provide some advice or direction, it is my intention that as we explore your feelings, choices, and goals, we will discover together the most appropriate and healthy decisions to for your life. I also recognize that you live within various systems (family, work, culture) that impact your life in different ways, and that counseling must include these components in the process.

I utilize Contextual, Cognitive-Behavioral, and Family Systems techniques in the counseling process. I will work with you on concrete thoughts and actions, and impacts of relationships, compassionately helping to make effective changes towards your goals.

As a Christian counselor, I believe that there is a spiritual aspect of life that should be recognized and included, in addition to the psychological and physiological aspects of counseling. I will seek to provide spiritual guidance when appropriate and only with your fully informed consent.

**Education & Training:** I hold a Bachelor of Arts degree in Psychology from Seattle Pacific University and a Master of Arts in Marriage and Family degree from George Fox University. I am also a Certified Drug & Alcohol Counselor in the state of Oregon.

My graduate coursework has included: Human Growth and Development, Personality and Counseling Theory, Psychopathology, Advanced Marriage & Family Therapy, Individual Counseling, Addictions (Drugs, Alcohol, and Sexual), Professional Ethics, and Counseling Supervision.

**License Information:** As a Licensed Professional Counselor (LPC) of the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT), I will abide by its Code of Ethics. Additionally, I am required to complete and document 40 hours of Continuing Education (CE) every two years, focusing on increasing knowledge and/or skills in areas such as theory and techniques of counseling/therapy, DSM diagnosis and assessment, and professional ethics.

**Fees, Payment, Insurance, & Cancellations:** Appointments are billed at \$100 per 50-minute session. Payments are due at the time of service. Accepted forms of payment are cash, checks, and debit/credit cards (plus \$1 fee per transaction). Insurance is not accepted at this time. Twenty-four hours notice is required for all cancellations. Failure to show up for an appointment or appointments cancelled in less than 24 hours will be charged at the full session rates stated above.

## PROFESSIONAL DISCLOSURE STATEMENT

**Client Bill of Rights:** The following client rights have been established by the Oregon State Board of Licensed Professional Counselors and Therapists [OAR 833-60-0001(4)(h)].

Consumers of counseling or therapy services offered by Oregon licensees have the right:

1. To expect that a licensee has met the minimal qualifications of training and experience required by state law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions:
  - a. Reporting suspected child abuse;
  - b. Reporting imminent danger to client or others;
  - c. Reporting information required in court proceedings or by client's insurance company, or other relevant agencies;
  - d. Providing information concerning licensee case consultation or supervision; and
  - e. Defending claims brought by the client against the licensee.
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

You may contact the Board at the following address and phone number:

Oregon Board of Professional Counselors and Therapists  
3218 Pringle Road SE, Suite 250  
Salem, OR 97302-6312  
503.378.5499

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**Client Signature**

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**Date**

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Others' Signature

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Date

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Aaron K. Potratz, LPC MA CADCI

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Date