Mark Henry Counseling Services, LLC

834 SW Saint Clair Ave. #206, Portland OR 97205
www.markhenrycounseling.com email: mark@markhenrycounseling.com
Phone: (503) 348-6205

Office Policies and Procedures

Welcome to my practice. I am a Licensed Professional Counselor #C1433 with a Master's of Arts in Counseling Psychology (1999) from Lewis and Clark College and a Master's in Education (1984) from Linfield College. I am governed by and follow the Code of Ethics of the State of Oregon Board of Licensed Professional Counselors and Therapists. The board can be contacted at 3218 Pringle Road SE, #250, Salem, OR 97302-6312, at (503) 378-5499, or by email: lpc.lmft@state.or.us.

I have training in Internal Family Systems, https://selfleadership.org/, focused on guiding people towards wholeness, connection with their deep self, and foster a stronger connection in their relationships. Also, I have trained with the Ketamine Training Center in ketamine assisted psychotherapy.

In order to stay current with new understanding in my field and maintain my license, I am required to participate in annual continuing education in classes that I believe will help me develop my practice and be beneficial to my clients. I maintain membership in the following associations: the Oregon Counselors Association, the Amsterdam Psychedelic Research Association, and the Ketamine Psychotherapy Associates.

Appointments and Telephone Calls
I offer online scheduling that a text or email reminder of your appointment. If for some reason you cannot make your scheduled appointment, please cancel as far in advance as possible. Twenty-four (24) hours notice between Monday and Friday is required to cancel an appointment.

Fees
The fee structure for 45-minute individual sessions is **$205,** group **$75,** and **$275** for 75-minute couples sessions. A 75-minute **INITIAL INTAKE** for individual sessions is **$275**. If you wish to submit a claim to your insurance, please contact Susan Bryant at Mountainview Medical Billing at (503) 779-7222 or Susan_mtviewmed@outlook.com. If you opt out of using your insurance and pay by cash or check, I offer a $20 discount.

Late cancellation and missed appointments will be billed as follows:

First occurrence – Half Fee
Additional occurrences - Full Fee

Client Rights and Confidentiality

You have the right to:

- ➢ Expect that Mark Henry has met the minimal qualifications of training and experienced required by state law;
- ➢ Be informed about Mark Henry's qualifications and experience and examine public records maintained by the Board of Licensed Professional Counselors and to have the Board confirm Mark Henry's credentials.
- ➢ Obtain a copy of the Code of Ethics;
- ➢ Report complaints to the Board;
- ➢ Be informed of the cost of professional services before receiving the services;
- ➢ Be informed about your therapy and the possible risks associated with therapy;
- ➢ Be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: a) Reporting suspected acts of abuse, such as child or elder abuse, or intend to commit such acts; b) Reporting imminent danger to client or others; c) Reporting information necessary in court proceedings, to process insurance claims, or other relevant agencies; d) Providing information concerning Mark Henry's case consultation or supervision; e) Defending claims brought by client against Mark Henry
- ➢ Be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

If you have any questions about confidentiality, please discuss them with me before revealing the information in question.

Emergencies

If you have an emergency, you can call 503.988.4888, or my cell at 503.348.6205. If I'm not available, or it is after hours, please call 503.988.4888, 911, or your local emergency room hospital.

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Intake Information

Name____**Email**:___________________________

Address____

____
City **State,** **Zip**

Home Phone______________________________ **Work Phone**___________________________

Mobile _______________________________ **Can I send appointment reminders to you by text or email? (circle a method)**

Date of Birth_____________________ **Age**_______ **Relationship Status** ___________________

Race _______________________ **Ethnicity** __________ **Disability status** __________________

Spoken languages ___________________________________

Written languages ___________________________________

Gender Identity _____________________ **Sexual Orientation** __________________________

Referred by____

Primary Care Doctor________________________________ **Phone Number**________________

OK to contact to coordinate care? Y___N___

Your Employer/School/ Occupation____

Medications/Nutritional Supplements____

____

Allergies____

Do you have any Current or ongoing concerns about your physical health?
____

____

Emergency Contact____**Phone**_______________________

INSURANCE PAYMENT FORM

I WISH TO NOT BILL MY INSURANCE COMPANY _____ (initial)
I agree to pay by cash or check (45 MINUTE FEE _________ and 75 MINUTE FEE _______)

Printed Client's Name ____

Signature ____ **Date** _______________

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS
See also "Consent to use & disclose your health info" I hereby authorize the provider to furnish my insurance company with all information requested concerning my present claim. I acknowledge that I am responsible for all charges not covered. I agree to pay in full for services leading to written reports prior to their release. _____ **(initial)**

Name of Insured Person____

Date of Birth__________________________(if different from client name)

Insurance Company____

Phone____

Subscriber#/I.D. #_____________________________________

Group#____

I have read, understood, and agree to the above policies, and acknowledge receipt of the notice to protect your health information. If you have any questions, please discuss them with me so that I may answer them to your satisfaction.

Printed Name ____

Signature____ **Date**__________________

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Options

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:
• "*PHI*" refers to information in your health record that could identify you.
• "*Treatment, Payment and Health Care Operations*"
• *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or your psychiatrist.
• *Payment* is when I obtain reimbursement for your health care. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for you health care or to determine eligibility for coverage.
• *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. I may also use and disclose your PHI to contact you regarding scheduling, appointment reminders, overdue bills, or to return your telephone calls.
• "*Use*" applies only to activities within my office such as applying, utilizing, examining, and analyzing information that identifies you.
• "*Disclosure*" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization
I may use or disclose PHI for purposes outside of *treatment, payment,* and *health care operations* when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of *treatment, payment and health care operations*, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

III. Uses and Disclosures with Neither Consent nor Authorization
I may use or disclose PHI **without** your consent or authorization in the following circumstances:
• **Child Abuse:** If there is a child abuse investigation, I may be compelled to turn over your relevant records. Additionally, I am required to report suspected abuse according to Oregon law.
• **Adult and Domestic Abuse:** If there is an elder abuse or domestic investigation, I may be compelled to turn over your relevant records. I may be required to report suspected abuse.
• **Health Oversight:** The Oregon State Board of Licensed Professional Counselors and Therapists may subpoena relevant records from me should I be the subject of a complaint.
• **Judicial or Administrative Proceedings:** In response to a subpoena or a court order or administrative order, if you are involved in a lawsuit or a dispute, or in response to a court order, subpoena, warrant, summons or similar process, if asked to do so by law enforcement, I may release your relevant records.
• **Serious Threat to Health or Safety:** I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I will limit disclosure of the otherwise confidential information to only those individuals/organizations and only that content which would be consistent with the standards of the profession in addressing such problems.
• **Workers Compensation:** If you file a workers compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials. This would include a past history of complaints or treatment of a condition similar to that in the complaint.
• **Required by Law:** I may use or disclose information as required by federal, state or local law officials.

IV. Patient's Rights and Psychotherapists Duties
Patient's Rights:
• *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of protected health information about you. While I will consider your request, I am not legally bound to agree.

If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, upon your request, I will send your bills to another address.)
• *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of your PHI that may be used to make decisions about your care for as long as the PHI is maintained in the record. I may deny your request to inspect and/or copy in certain limited circumstances, and if I do this, you may ask the denial decision to be reviewed.
• *Right to Amend:* If you believe that there is some error in your PHI or that important information has been omitted, you have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your request and the reason for it must be made in writing. I may deny your request if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. On your request, I will discuss with you the details of the amendment process.
• *Right to and Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent or authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the amendment process.
• *Right to a Paper Copy:* You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Clinician's Duties:
• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
• I reserve the right to change the privacy policies and practices described in this notice, and these changes will apply to PHI already on file.
• If I revise my policies and procedures, I will have a current copy available in my office and you can also request one from me and I will mail it to you.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact me and we will discuss the situation. If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me at my office, Mark T. Henry, 921 SW Washington, #460, Portland OR 97205. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. You will not be penalized for exercising your right to file a complaint.

VI. Effective Date: August 19, 2017

Signature ____ Date ___________________