# WILLIAM POWELL

MSW LCSW

1201-c NE 7th Street Grants Pass, OR 97526


Welcome. The information I am having you fill out will be kept confidential. It helps me both understand your situation and concerns. When we meet please feel free to ask me any questions you may have. I look forward to our meeting.

Name:_____ Date:_____

Mailing address:_____

_____

Phone:_____ cell:_____ other:_____

Date of Birth:_____ Age:_____ Gender: ____Male ____Female
Social Security #: _____

Occupation:_____

If you were in the military, what branch?_____ Active combat? _____
Dates of service_____

If currently married, date of marriage_____ Spouse's name_____

Number of people living in the home _____.

Dates of prior marriage(s):_____

Have you had mental health counseling previously? __yes __no. If yes,
When_____ With whom_____

Your physicians name _____ Date of last visit_____

| Please list all medications | Use | Dosage |
|---|---|---|
| (example Prozac | depression | 20mg 2xday) |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

PLEASE ALSO FILL OUT BACK (OVER)

Please list all major illnesses or surgeries and the year occurred _____

_____

_____

Other health related conditions_____

Which of the following describe or relate to the concerns which bring you here:
__Aging issues __Anger __Anxiety __Frequent crying __Eating/food __Alcohol __Drugs
__Loneliness __Self doubt __Guilt __Sexual concerns __Fear __Grief __Mid-life issues
__Suicidal feelings/thoughts __Religious doubts __Legal issues __Finances __Physical health
__Vocation/Career issues __Self esteem __Poor appetite __Sleep disturbance __Hopelessness
__Weight loss __Physical abuse __Sexual abuse __Emotional abuse __Loss(es) __Depression
__Relationship issues with __Kids __Parents __Children __ Spouse/Partner __other.
__Addiction to _____.
__Other _____.

State in your own words the concerns that bring you to therapy: _____

_____

_____.

What do you hope to achieve in therapy (your goals/expectations)?_____

_____

_____.

I am requesting treatment from William Powell, LCSW

_____
Client signature

Who referred you here? Name (if known)_____
__Physician or Physician's office __Insurance company __Family/friend
__Yellow pages/Phone book __Pastor/Church __Former Client
__Agency (Please specify)_____.
__Other (Please specify) _____. _ INTERNET

# WILLIAM POWELL
MSW LCSW

1201-c NE 7th Street
Grants Pass, OR 97526

office(541) 472-8222
fax (541) 472-8222


## FEE AGREEMENT

My standard counseling fee is $150 per counseling hour (a 45-50 minute counseling session). I also charge $220 for the first session as an intake/assessment for people billing insurance. IF YOU ARE USING MY SLIDING SCALE, PLEASE REFER TO THAT PRICE LIST, NOT THESE #'s. These fees can be paid in a number of ways. I accept insurance reimbursements and payments from some Employee Assistance Programs (EAP). If you have insurance you are expected to pay whatever co-pays or deductibles as required by your insurance company.

| | |
|---|---|
| *First session-Intake/Assessment | $220 |
| *Standard fee for 45-50 minute sessions | $150 |

__ Please bill my insurance
__ Please bill _____
__ Use of the sliding scale with agreed on fee of $_____
__ other _____

PLEASE NOTE BELOW FINANCIAL POLICIES:

* I agree to pay for sessions/co-pays at the time of service.
* If my insurance company does not pay for the services rendered, I am responsible for paying the full amount of the fees. William Powell recommends that you personally contact your insurance company and check benefits before you start counseling.
* I am fully responsible for all fees assessed to my account.
* I will pay a $75 fee if I miss an appointment (no show), cancel with less than 24 hours notice, or am more than 15 minutes late. (Except when prohibited by insurance regulations such as Medicare/Medicade). This fee is paid by you, not your insurance company.
  If you voluntarily miss one session and are unable to pay the no show fee we will discuss termination.

*If you are going to pay by check please make it out to William Powell.

_____ _____ _____
Client Signature Client Signature Date

PLEASE ALSO FILL OUT BACK (OVER)

William Powell, MSW LCSW INSURANCE INFORMATION

CLIENT NAME:_____ DOB:_____ SS#: _____

PRIMARY INSURED NAME:_____ DOB: _____ SS#:_____

PRIMARY INSURED EMPLOYER: _____

POLICY ID#: _____ GROUP #: _____

INSURANCE COMPANY: _____

(**IF YOU HAVE A COPY OF YOUR CARD I CAN XEROX AND YOU DO NOT NEED TO FILL OUT THIS SECTION.

INSURANCE COMPANY ADDRESS: _____

_____

PHONE #: _____

SECONDARY INSURANCE COMPANY: _____

ADDRESS: _____

PHONE #: _____ **)

POLICY NUMBERS:_____

I hereby authorize William Powell and his billing service to provide summary of care and assessment information regarding evaluations and treatment for the purpose of processing claims for benefits. I further authorize payment of medical benefits to William Powell, LCSW for services provided.

_____ DATE: _____

CLIENT/ LEGAL GUARDIAN

WILLIAM POWELL MSW/LCSW (licenced clinical social worker)
Phone 541-472-8222 email: wmpowelllcsw@gmail.com

The following is an outline of information you may find helpful. Please keep this paper for future reference. This information will cover how to contact me, counseling style/techniques you can expect, and general information about the work you and I may choose to be a part of.

## EDUCATION & PROFESSIONAL AFFILIATION

Mr. Powell has a Bachelor of Science (B.S) degree with a major in psychology from Xavier University in Cinti. Ohio; a Master of Social Work (M.S.W.) from Virginia Commonwealth University, and is licensed by the Oregon State Board of Clinical Social Work as an Licensed Clinical Social Worker.

## CONTACTING ME

If you wish to leave a message, you can call the office anytime and usually you will get the answering machine. Your messages are confidential. Emails are also a very good way to communicate with Mr. Powell and he can send and receive such at WMPOWELLLCSW@GMAIL.COM. That is 3 "L's" not 2.

## EMERGENCIES

In the event you have a mental health emergency you have many options. William Powell is not available for immediate needs but will respond to messages as he is able. He may be unavailable or out of town for long periods of time so he is NOT a good resource for immediate crisis needs. In the event that you have a crisis and need immediate assistance you can call 911 (for life threatening situations), you can go to the nearest hospital, and/or you can call 541-474-5360 (24 hour county crisis team) and ask to speak with a crisis worker. Mr. Powell is almost never available without an appointment and does not see people in emergencies without an appointment. It is recommended that you always call rather than "drop by." If you "drop by" the office is not set up to notify Mr. Powell that you are even here.

## COUNSELING

The goal for counseling is for you to develop tools/resources, sort out issues, improve areas of concern, and/or experience relief of symptoms. Grants Pass has many different types of counselors, and each have their own style. Mr. Powell tends to use the following methods/styles:

| | | |
|---|---|---|
| *Open conversation | *processing/talking through | *grief work |
| *developing tools | *asking open ended questions | *making connections |
| *linking events to present | *clarifying roles | *encouraging family support *Etc. |

William Powell does **not**: *give medical advice or prescribe medication or use hypnosis

I have received a copy of this page _____ _____
(PLEASE SIGN THIS COPY) Client signature Date

## RIGHTS AND RESPONSIBILITIES

As a client you have the right to:

* Prompt, confidential, and respectful service.
* Know where you are in the treatment process including probable length of treatment.
* Obtain a copy of your treatment plan and records.
* Know fees and billing procedures.
* Request a different therapist.
* Know that your records will be kept in a locked storage, not to be shared with anyone without your written permission **unless** court ordered or where **reporting of an extreme risk to life or child/elderly abuse** as required by law. Parents also have rights to records with minors.
* Know records are destroyed after seven years of inactivity.
* Refuse services with Mr. Powell.
* Submit Complaints.
* Know that Mr. Powell uses a billing service and your information and diagnosis will be used to collect payments if you request for an insurance company to be billed.

LIMITATIONS: Mr. Powell's work with you has many limitations. You are welcomed to seek further assessment from a physician, a psychiatrist, and/or complete psychological testing with a psychologist to assure the most accurate diagnoses and treatment. Mr. Powell treats a variety of mental health issues but does not claim to use "the best" treatment and he is not "an expert."

## HIPPA NOTICE

Hippa is a federal law that guides how healthcare information is to be used. Below is an outline for your information.

* When Mr. Powell assesses, diagnoses, treats, or refers you, this information collected is what the law calls (PHI) Protected Healthcare Information. Mr. Powell can share this information with others who provide treatment to you, to arrange payment for your treatment, or for other reasons when required by law to do so.

* You have a right to see and get copies of your records.

* You have a right to correct or update your records.

* You can file complaints about medical privacy by calling the Office of Civil Rights at 1-866-627-7748
* Other rights include Right to get a list of disclosures, Limits on use of disclosures of PHL, Revoking permission, Choosing how Mr. Powell communicates with you, etc..

HIPPA can be complicated to many, please ask Mr. Powell any questions or for a more thorough written explanation of HIPPA rules and explanations.

I have received a copy of the above,

_____ _____ _____

Client Client Date

PLEASE SIGN THIS COPY AND TAKE NEXT COPY.

# WILLIAM POWELL MSW/LCSW (licenced clinical social worker)

Phone 541-472-8222 email: wmpowelllcsw@gmail.com

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HIPPA can be complicated to many, please ask Mr. Powell any questions or for a more thorough written explanation of HIPPA rules and explanations.

I have received a copy of the above,

[redacted] [redacted] [redacted]

THIS IS YOUR COPY TO KEEP

NAME:
DATE:

## Beck Depression Inventory

Choose one statement from among the group of four statements in each question that best describes how you have been feeling during the **past few days**. Circle the number beside your choice.

| | | | |
|---|---|---|---|
| 1 | **0** I do not feel sad.<br>**1** I feel sad.<br>**2** I am sad all the time and I can't snap out of it.<br>**3** I am so sad or unhappy that I can't stand it. | 8 | **0** I don't feel I am any worse than anybody else.<br>**1** I am critical of myself for my weaknesses or mistakes.<br>**2** I blame myself all the time for my faults.<br>**3** I blame myself for everything bad that happens. |
| 2 | **0** I am not particularly discouraged about the future.<br>**1** I feel discouraged about the future.<br>**2** I feel I have nothing to look forward to.<br>**3** I feel that the future is hopeless and that things cannot improve. | 9 | **0** I don't have any thoughts of killing myself.<br>**1** I have thoughts of killing myself, but I would not carry them out.<br>**2** I would like to kill myself.<br>**3** I would kill myself if I had the chance. |
| 3 | **0** I do not feel like a failure.<br>**1** I feel I have failed more than the average person.<br>**2** As I look back on my life, all I can see is a lot of failure.<br>**3** I feel I am a complete failure as a person. | 10 | **0** I don't cry any more than usual.<br>**1** I cry more now than I used to.<br>**2** I cry all the time now.<br>**3** I used to be able to cry, but now I can't cry even though I want to. |
| 4 | **0** I get as much satisfaction out of things as I used to.<br>**1** I don't enjoy things the way I used to.<br>**2** I don't get any real satisfaction out of anything anymore.<br>**3** I am dissatisfied or bored with everything. | 11 | **0** I am no more irritated by things than I ever am.<br>**1** I am slightly more irritated now than usual.<br>**2** I am quite annoyed or irritated a good deal of the time.<br>**3** I feel irritated all the time now. |
| 5 | **0** I don't feel particularly guilty.<br>**1** I feel guilty a good part of the time.<br>**2** I feel quite guilty most of the time.<br>**3** I feel guilty all of the time. | 12 | **0** I have not lost interest in other people.<br>**1** I am less interested in other people than I used to be.<br>**2** I have lost most of my interest in other people.<br>**3** I have lost all of my interest in other people. |
| 6 | **0** I don't feel I am being punished.<br>**1** I feel I may be punished.<br>**2** I expect to be punished.<br>**3** I feel I am being punished. | 13 | **0** I make decisions about as well as I ever could.<br>**1** I put off making decisions more than I used to.<br>**2** I have greater difficulty in making decisions than before.<br>**3** I can't make decisions at all anymore. |
| 7 | **0** I don't feel disappointed in myself.<br>**1** I am disappointed in myself.<br>**2** I am disgusted with myself.<br>**3** I hate myself. | 14 | **0** I don't feel that I look any worse than I used to.<br>**1** I am worried that I am looking old or unattractive.<br>**2** I feel that there are permanent changes in my appearance that make me look unattractive.<br>**3** I believe that I look ugly. |

CONTINUED ON BACK
(OVER)

| | | | |
|---|---|---|---|
| 15 | **0** I can work about as well as before.<br>**1** It takes an extra effort to get started at doing something.<br>**2** I have to push myself very hard to do anything.<br>**3** I can't do any work at all. | 19 | **0** I haven't lost much weight, if any, lately.<br>**1** I have lost more than five pounds.<br>**2** I have lost more than ten pounds.<br>**3** I have lost more than fifteen pounds.<br>(Score 0 if you have been purposely trying to lose weight.) |
| 16 | **0** I can sleep as well as usual.<br>**1** I don't sleep as well as I used to.<br>**2** I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.<br>**3** I wake up several hours earlier than I used to and cannot get back to sleep. | 20 | **0** I am no more worried about my health than usual.<br>**1** I am owrried about physical problems such as aches and pains, or upset stomach, or constipation.<br>**2** I am very worried about physical problems, and it's hard to think of much else.<br>**3** I am so worried about my physical problems that I cannot think about anything else. |
| 17 | **0** I don't get more tired than usual.<br>**1** I get tired more easily than I used to.<br>**2** I get tired from doing almost anything.<br>**3** I am too tired to do anything. | 21 | **0** I have not noticed any recent change in my interest in sex.<br>**1** I am less interested in sex than I used to be.<br>**2** I am much less interested in sex now.<br>**3** I have lost interested in sex completely. |
| 18 | **0** My appetite is no worse than usual.<br>**1** My appetite is not as good as it used to be.<br>**2** My appetite is much worse now.<br>**3** I have no appetite at all anymore. | | |

NAME:



DATE:

## *Beck Anxiety Inventory*

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

| | Not At All | Mildly but it didn't bother me much. | Moderately - it wasn't pleasant at times | Severely – it bothered me a lot |
|---|---|---|---|---|
| Numbness or tingling | 0 | 1 | 2 | 3 |
| Feeling hot | 0 | 1 | 2 | 3 |
| Wobbliness in legs | 0 | 1 | 2 | 3 |
| Unable to relax | 0 | 1 | 2 | 3 |
| Fear of worst happening | 0 | 1 | 2 | 3 |
| Dizzy or lightheaded | 0 | 1 | 2 | 3 |
| Heart pounding/racing | 0 | 1 | 2 | 3 |
| Unsteady | 0 | 1 | 2 | 3 |
| Terrified or afraid | 0 | 1 | 2 | 3 |
| Nervous | 0 | 1 | 2 | 3 |
| Feeling of choking | 0 | 1 | 2 | 3 |
| Hands trembling | 0 | 1 | 2 | 3 |
| Shaky / unsteady | 0 | 1 | 2 | 3 |
| Fear of losing control | 0 | 1 | 2 | 3 |
| Difficulty in breathing | 0 | 1 | 2 | 3 |
| Fear of dying | 0 | 1 | 2 | 3 |
| Scared | 0 | 1 | 2 | 3 |
| Indigestion | 0 | 1 | 2 | 3 |
| Faint / lightheaded | 0 | 1 | 2 | 3 |
| Face flushed | 0 | 1 | 2 | 3 |
| Hot/cold sweats | 0 | 1 | 2 | 3 |
| **Column Sum** | | | | |

[redacted]

NAME:

DATE:

# Amen ADD Questionnaire

Please rate each question with a number that is closest to your experience

0 Never
1 Rarely
2 Occasionally
3 Frequently
4 Very Frequently
n/a Not Applicable

___ I am easily distracted.
___ I have difficulty sustaining attention span for most tasks in school/work.
___ I have trouble listening when others are talking.
___ I have difficulty following through (procrastination) on tasks or instructions.
___ I have difficulty keeping an organized area.
___ I have trouble with time, for example, am frequently late or hurried, tasks take longer than expected, turn in projects late or last minute.
___ I have a tendency to lose things.
___ I make careless mistakes, poor attention to detail.
___ I am forgetful.
___ I daydream excessively.
___ I complain of being bored.
___ I appear apathetic or unmotivated.
___ I am tired, sluggish, or slow-moving.
___ I am spacey or seem preoccupied.
___ I am hyperactive.
___ I have trouble sitting still.
___ I am fidgety, in constant motion (hands, feet, body)
___ I am noisy, have a hard time being quiet.
___ I act as if I'm "driven by a motor."
___ I talk excessively.
___ I am impulsive (I don't think through comments or actions before they are said or done).
___ I have difficulty waiting my turn.
___ I interrupt or intrude on others.

(OVER)

| | | | |
|---|---|---|---|
| 1. | Has there ever been a period of time when you were not your usual self and (while not on drugs or alcohol) ... | | |
| | ...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | Yes | No |
| | ...you were so irritable that you shouted at people or started fights or arguments? | Yes | No |
| | ...you felt much more self-confident than usual? | Yes | No |
| | ...you got much less sleep than usual and found you didn't really miss it? * | Yes | No |
| | ...you were much more talkative or spoke faster than usual? | Yes | No |
| | ...thoughts raced through your head or you couldn't slow you mind down? | Yes | No |
| | ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | Yes | No |
| | ...you had much more energy than usual? | Yes | No |
| | ...you were much more active or did many more things than usual? | Yes | No |
| | ...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? | Yes | No |
| | ...you were much more interested in sex than usual? | Yes | No |
| | ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | Yes | No |
| | ...spending money got you or your family into trouble? | Yes | No |

| | |
|---|---|
| 2. | If you checked YES to more than one of the above, have several of these ever happened during the *same period of time*?<br><br>*YES* *NO* |
| 3. | How much of a *problem* did any of these cause you -- like being unable to work/; having family, money, or legal troubles; getting into arguments or fights?<br><br>No Problem Minor Problem Moderate Problem Serious Problem |

# William Powell, LCSW

## EMAIL CONSENT FORM

Below is some info i pulled together about emailing. I like emails, but am required to share limits and risks.

1. RISK OF USING E-MAIL Provider offers clients the opportunity to communicate by e-mail. Transmitting client information by e-mail, however, has a number of risks that clients should consider before using e-mail. These include, but are not limited to, the following risks: a. E-mail can be circulated, forwarded, and stored in numerous paper an electronic files. b. E-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients. c. E-mail senders can easily misaddress an email. d. E-mail is easier to falsify than handwritten or signed documents. e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy. f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems. g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection. h. E-mail can be used to introduce viruses into computer systems. i. E-mail can be used as evidence in court. 2. CONDITIONS FOR THE USE OF E-MAIL Provider will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Provider cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, the clients must consent to the use of e-mail for client information. Consent to the use of e-mail includes agreement with the following conditions: a. All e-mails to or from the client concerning diagnosis or treatment will be printed out and made part of the client's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails. b. Provider may forward e-mails internally to Provider's staff and agent necessary for diagnosis, treatment, reimbursement, and other handling. Provider will not, however, forward emails to independent third parties without the client's prior written consent, except as authorized or required by law. c. Although Provider will endeavor to read and respond promptly to an e-mail from the client, Provider cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the client shall not use e-mail for medical emergencies or other time sensitive matters. d. If the client's e-mail requires or invites a response from Provider, and the client has not received a response within a reasonable time period, it is the client's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond. e. The client should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. f. The client is responsible for informing Provider of any types of information the client does not want to besent by e-mail, in addition to those set out in 2(e) above. g. The client is responsible for protecting his/her password or other means of access to e-mail. Provider is not liable for breaches of confidentiality caused by the client or any third party. h. Provider shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines. i. It is the client's responsibility to follow up and/or schedule an appointment if warranted. 3. INSTRUCTIONS To communicate by e-mail, the client shall: a. Limit or avoid use of his/her employer's computer. b. Inform Provider of changes in his/her email address. c. Put the client's name in the body of the e-mail. d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing question). e. Review the e-mail to make sure it is clear and that all relevant information if provided before sending to Provider. f. Inform Provider that the client received an e-mail from Provider. g. Take precautions to preserve the confidentiality of e-mail, such as using screen savers and safeguarding his/her computer password. h. Withdraw consent only by e-mail or written communication to Provider.

4. client ACKNOWLEDGEMENT AND AGREEMENT I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with clients by e-mail. Any questions I may have had were answered.

_____ _____ Client signature and date

If you were referred to me by a health care professional (e.g. your doctor, nurse practitioner, etc.) or if you are seeing a health care professional for medication, I would like permission from you to share information with this person. In order for them to keep up to date with your care and symptoms, I request permission to send them a letter and possibly updates. Preferably I would send them symptoms, progress, and my opinions.

If you sign the release of information on the back of this page I will then send this information out.

Should this not seem helpful, confusing, or you are simply reluctant for me to make this correspondence, simply do not sign this release form and I will not even make contact with your health care professional. If you are willing please sign this attached release or discuss it with me when we meet.

[This release can also be used by you to give me permission to release information with another person or agency. If you wish for me to correspond with someone other than your health care professional please discuss this with me].

William Powell. LCSW

PLEASE ALSO FILL OUT BACK (OVER)

William Powell MSW/LCSW[redacted]
1201-c N.E. 7TH STREET
GRANTS PASS OR. 97526
office #: 541-472-8222 fax #: 541-472-8222

# AUTHORIZATION TO RELEASE INFORMATION

I authorize William Powell to use and disclose the specific health information described below regarding below client (or write in name_____) consisting of:

1) Progress reports oral and written.
2) Mental Health diagnoses and symptoms.
3) Mental health symptoms.
4) Treatment needs.
5) Aftercare planning, options, & recommendations.
6) Opinions.
7) Written reports, evaluations, and discharge summary.
8) Drug & Alcohol diagnoses and symptoms.

To and From: _____
For the purpose of coordination of services, client request, and improved care.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer protected under federal law.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for service. You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization please send a written statement to the above address and state that you are revoking this authorization.

I have read this authorization and understand it. Unless revoked, this authorization expires in eight months from the below date (or write in expiration date _____).

Signature: X_____ Date: _____
(PLEASE SIGN ABOVE)

_____ _____
Print Name Date of birth