Kay Endres, LCSW
503.927.7735
kayendrescounseling@gmail.com

WELCOME

OFFICE LOCATIONS

Portland office: 1012 SW King; Suite 304; Portland, OR 97205. Located on the corner SW Salmon and King Ave., Victorian House, third floor. Parking is on the street and adequate, but allow enough time to park. In the event the door is lock, call me at 503.927.7735. and I will let you in.

Hood River Office: 116 Third Street; Suite 215; Hood River, OR 97031. Located downtown Hood River. Parking on street with meters, usually 1.00 an hour. If the main entry door is locked, please call me at 503.927.7735.

APPOINTMENTS

Each session is scheduled for 55 minutes. During that time, we will work together to understand the nature of the challenges that have brought you to counseling. We will develop a plan to create the needed changes. Occasionally individuals may go through periods in therapy which result in emotional discomfort, changes in relationships, or temporary worsening of symptoms. This should subside as the treatment progress.
If you are unable to attend a scheduled session, notification of 24 hours is required. Without this notification, a charge for the full amount of the session will be made. In the event of my scheduling error, you will receive the full session fee.

FEES

The fee for each session is $125.00 and is due at the time of the appointment. If you have a medical condition covered by health insurance, we can discuss details of payment and billing. Regardless of the amount of insurance coverage, you are responsible for the entire fee of the session. *Payment for missed appointments is due prior to the next scheduled appointment.* Failure to pay fees may result in a discontinuation of services. Your credit card or debit card can be used for sessions or co-pay responsibility.

PROFESSIONAL QUALIFICATIONS

I received a Master of Social Work from University of Illinois. I have been a Licensed Clinical Social Worker in 1992. I am a member of the National Association of Social Worker. As a part of my license requirements, I participate in a wide variety of continuing education and training experiences. As a personal and professional commitment, I counsel only in the areas of my competency from training and/or experience.

ETHICAL TREATMENT
I subscribe to the Code of Ethics adopted by the National Association of Social Workers. I would be happy to provide a copy of this for you and discuss any issues that arise regarding ethics.

REFERRALS
I welcome and appreciate all referrals.
If I find as I work with you that we come upon a problem outside of my training and/or competence, I will facilitate a referral to another health professional. If you have doubts about the appropriateness or effectiveness of your treatment with me, please discuss this with me as soon as possible. I am happy to provide any referrals whenever the need arises for yourself, your family, or your friends.

EMERGENCIES
In the event of an emergency in which you need immediate assistance, call the Portland Metro Crisis Line at: 503-988-4888. In Hood River 1.888.877.9147 or Providence Memorial Hospital Emergency Room 541.387.6325. If necessary call 911 or go to hospital emergency room.

COLLATERAL CONTACTS
As a part of my philosophy, I like to include family members when appropriate. It provides an important perspective for understanding the difficulties and gaining support for solutions. Bringing key people at certain times during therapy can be an important part of success.

QUESTIONS
I welcome questions about any aspect of the counseling and therapy process. I encourage an atmosphere of honesty, openness, and collaboration.

By signing below, I acknowledge that I have received a copy and understand the information above. I give my consent to treatment with Kay Endres, LCSW.

Client's Name **Date**

Legal Guardian's Name **Date**

Client Information
(One person to be identified)

Name_____ Date _____

Address _____
(Street)

_____
(City) (State) (Zip)

Email: _____
Can I send you my newsletter via email? ☐ Yes ☐ No

Phone (cell) _____ (home) _____ (work) _____

Referred by _____

Employer _____ Occupation _____

***Date of Birth** _____ age _____ gender _____M _____ F

Emergency Contact (name) _____ cell phone: _____

Health Insurance
Copy Front & back of Insurance Card

Insurance Company:

_____

Name of Insured & their DOB_____

ID # _____ Group #_____

Yearly Deductible _____ Co-pay_____

I authorize the release of any medical information necessary to process a claim. I also request payment of government benefits either to myself or to the party who accepts assignment. I authorize payment of medical benefits to the provider of services.

_____
Signature

INTAKE EVALUATION

Date:
Client:
Spouse/Partner/Parent's Name:

Family and Marital History

Married _____ Divorced _____ Single _____ Widowed _____

Previous marriages & dates: _____

Children's or sibling's name and ages

Presenting Issue(s)

Describe why you came here today. What are the most pressing issues?

Have you been to counseling before? When and was it helpful?

Significant medical history, including allergies

List current medications

SUBSTANCE USE HISTORY

Do you use/have used tobacco? No___ currently _____ past _____
Do you use/have used alcohol No___ currently _____ past _____
Do you use/have used drugs No___ currently _____ past _____
Do you consider your use of any substances to be problematic? Yes____ No_____

PLEASE CHECK ANY SYMPTOMS YOU ARE CURRENTLY HAVING:

Depression		Feeling hopeless	
Extreme sadness		Feeling tearful	
Trouble concentrating		Change in sleeping habits	
Memory problems		Lack of energy	
Change in eating habits		Weight changes	
Feelings of extreme happiness		Change in sexual interest	
Trouble performing your job		Problems with family/friends	
Lack of enjoyment of usual activities		Feeling stressed	
Self esteem problem		Easily irritated	
Perfectionism		Feeling guilty	
Obsessions or compulsions		Feeling nervous	
Feeling fearful		Sudden feelings of panic	
Physical complaints of pain		Muscle tension	
Problems with anger		Acting violently	
Thoughts about hurting yourself/others		Thoughts about killing yourself/others	

Please look over the list and identify the 3 pressing symptoms that are causing you the most concern now:

Is there anything that should be discussed that has not been identified that might have an impact in counseling?

ACKNOWLEDGMENT AND CONSENT

I understand that Kay Endres, LCSW will use and disclose health information about me to my insurance company. I understand my health information may include information both created and received, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Kay Endres, LCSW may use and disclose health information in order to:

* make decisions about and plan 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 my practitioner/provider's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Kay Endres, LCSW will handle health information about me. The written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made, the information practices followed by Kay Endres, LCSW and my rights regarding my health information. I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Privacy Practices will be in the office.

I understand that 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 Practices and I understand that Kay Endres, LCSW is not required by law to agree to such requests. The official web site of HIPAA is: http://aspe.hhs.gov/admnsimp/

By signing below, I agree that I reviewed and understand the information above and that I have acknowledged the Notice of Privacy Practices.

Date: Client

OR

Date: Parent's of Client