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Clinical Psychologist
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Hillsboro, OR 97123
(503)840-2053

Informed Consent to Treatment

Welcome

Welcome to my practice. This document provides information about me, the services I provide, my business policies, and your rights as a client. Please read it carefully and ask any questions you may have about this information. When you sign this document it will constitute an agreement between us and marks the beginning of our therapeutic relationship.

About Me

I am a licensed clinical psychologist in Oregon registered with the Oregon Board of Psychologist Examiners. I earned my doctorate in clinical psychology from Pacific University in August 2013, after serving my internship at Kentucky River Community Care. Prior to my internship, I earned my masters in clinical psychology from Pacific University (2007), and a bachelor degree in psychology from Eastern Washington University (2003). I have been practicing as a mental health therapist since 2006 in a variety of settings including college counseling centers, outpatient mental health clinics, addictions programs, day treatment programs for severe and persistent mental illness, a day treatment program for developmental and intellectual disabilities, and secure sub-acute residential adult/child/adolescent treatment facilities. I also have experience providing in-home parent training for families involved with Child Welfare.

Philosophy & Approach

I will be seeking to build a collaborative relationship with you in order to more effectively understand the issues you may be dealing with and to help find ways to solve them. I use my clinical expertise to integrate various psychological theories and techniques, tailoring the therapy experience to your needs and personality. As part of this process, I believe strongly that considering your culture is central to understanding your life and issues, as well as learning how culture and community may support and/or hinder your efforts.

Fees

The fees for my services are as follows:
Intake session (50 minutes): $185
Individual session (50 minutes): $150
Couple/Family session (50 minutes): $150
Group session (90 minutes): $30/participant

On a limited basis, we may agree on a reduced fee for services if your financial situation warrants. The reduced fee will be within an established "sliding scale" of payment and is only available to a certain number of clients at any given time. Payment agreements outside of my normal fees will be documented, kept on file, and reviewed quarterly to determine continuing eligibility.

Date________ Client's Initials________

Payment, Insurance, & Fees
Payment of our agreed upon fee or copay is due at the time of service. I am happy to bill insurance companies for whom I am in-network, and I will provide a receipt that you may submit to out-of-network insurance plans for reimbursement. It is important that you contact your insurance company to inquire about mental health benefits before we begin working together and understand how much of my fee your insurance will reimburse to you.

In the event that your account becomes past-due and we have not agreed on a payment plan, I have the option to use legal means to secure payment, including hiring a collections agency or using small claims court; the costs of pursuing such options will be included in the claim. Generally, the only health information that I will release is your name, the nature of the services provided, and the amount due.

Cancellation Policy
Please contact me at least 24 hours prior to your appointment if you need to cancel your appointment. If you are unable to provide me with 24 hours' notice you will be charged half the rate for your missed appointment. In the case of a no-call and no-show you will be charge the full rate of your missed appointment.

Contacting Me
When I am unavailable by phone, please leave a voicemail message at (503)840-2053 and I will return your call as soon as I am available. **Please do not include confidential information in your voice message.** In the digital era, it is safest to consider only face-to-face contact as confidential.

Emergencies:
If you need support immediately and cannot get ahold of me, please call the **Washington County Crisis Line at (503)291-9111.** If you believe you may be a risk to the safety of yourself or others, please call 911 or go to the nearest emergency room or hospital.

Confidentiality – Rights & Limitations
Information you share with me during our therapeutic work is kept confidential in the strictest sense possible under the law, however, there are some limitations that may occur that cause me to break confidentiality. These exceptions include:

Abuse of Children, Elderly Persons, Mentally Ill Adults, Developmentally Disabled Adults, or Animals: If I have reasonable cause to believe that a child or elderly person has been abused (by you or another party), I may be required to report the abuse.

Domestic Violence: If I have reasonable cause to believe you are the victim or perpetrator of domestic/partner violence that is impacting children, I may have an ethical obligation to disclose your personal health information to prevent harm to you or others.

Date________ Client's Initials________

Serious Threat to Health or Safety: I may disclose confidential information when I judge that discloser is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.

Even in these cases I will work to preserve your privacy to the best of my ability. Any third-party requests to release your information will need to be reviewed and approved by you. You have a right to request and understand information shared including with whom the information was shared and for what reason it is shared. Please see your notice of privacy rights for more information.

Consent to Treatment

Your signature below indicates that you have read and understand this document that you have:
____ Read and understood this document
____ That you have received and reviewed a copy of the Notice of Privacy Practices
____ And that any questions you may have were answered to your satisfaction.

Your signature indicates your agreement with the terms of this document and your desire to enter into therapy with me. Thank you for inviting me to join you on your personal journey. I look forward to working together!

Client Signature Date
Client's Printed Name
Tonya Boyd, PsyD Date
Clinical Psychologist

TONYA BOYD, PSYD

CLINICAL PSYCHOLOGIST

535 SE WASHINGTON ST
HILLSBORO, OR 97123
(503) 840-2053
DRTONYABOYD@GMAIL.COM
WWW.DRTONYABOYD.COM

Client Information Date:____________________

Name:______________________________ Nickname: ________________________________

Date of Birth:______/_____/___________ SSN:________-__________-______________________

Address:____

City: ______________________________State:_____________Zip:______________

PHONE NUMBERS OK to leave Messages?

HOME:__________________________________ ◯ Yes ◯No ◯ Primary Contact?

WORK:__________________________________ ◯ Yes ◯No ◯ Primary Contact?

MOBILE:________________________________ ◯ Yes ◯No ◯ Primary Contact?

EMAIL: ____

EMERGENCY CONTACT: Name:__________________ Phone:____________ Relation:________________

Who referred you? ____

May I thank them for the referral? ____

Gender:______________________________ Sexual Orientation: ______________________________

Preferred Pronoun: ________________________________

Racial and/or ethnic group identification: ____

Please describe what brought you here today:

____

____

____

Have you sought treatment for this problem before? Yes No

How is your sleep? (how many hours/night, waking, difficulty)

____

____

Have you gained or lost weight without trying in the last six months? Yes No

Are you struggling with any the following?

- ◯Aggression
- ◯Alcohol or drug use
- ◯Anxiety/worry
- ◯Body image concern
- ◯Change in appetite
- ◯Compulsive behavior
- ◯Crying spells
- ◯Distractibility
- ◯Eating problems
- ◯Fatigue
- ◯Gambling problems
- ◯Guilt/shame
- ◯Hallucinations
- ◯Hearing voices
- ◯Hopelessness
- ◯Hyperactivity
- ◯Impulsivity
- ◯Irritability
- ◯Loneliness
- ◯Loss of pleasure
- ◯Low self-worth
- ◯Memory difficulties
- ◯Nightmares
- ◯Obsessive thoughts
- ◯Overuse of internet
- ◯Panic attacks
- ◯Parenting problems
- ◯Racing thoughts
- ◯Relationship problems
- ◯Sadness
- ◯Self-harm
- ◯Sexual problems
- ◯Sleep problems
- ◯Stress
- ◯Suspicion/paranoia
- ◯Thoughts of death
- ◯Thoughts of harming others
- ◯Wide mood swings
- ◯Work/school problems

Are any of the following impacted by what brings you in?

- ◯Exercise
- ◯Finances
- ◯General health
- ◯Handling everyday tasks
- ◯Housing
- ◯Relationships
- ◯Hygiene
- ◯Legal matters
- ◯Sexual functioning
- ◯Recreational activities
- ◯Self-esteem
- ◯Sexual activity
- ◯Spirituality/faith

Have you ever had thoughts, made statements, or attempted to hurt yourself? ◯ Yes ◯ No

Have you ever had thoughts, made statements, or attempted to hurt someone else? ◯ Yes ◯ No

Have you ever had any of the following experiences?

- ◯Crime victim
- ◯Emotional abuse
- ◯Homelessness
- ◯Life threatening illness
- ◯Adoption
- ◯Live in a foster home
- ◯Loss of loved one
- ◯Multiple family moves
- ◯Neglect
- ◯Parental substance abuse
- ◯Physical abuse
- ◯Placed a child for adoption
- ◯Serious auto accident
- ◯Sexual abuse or assault
- ◯Violence in the home

Personal History

Family of Origin: Please list the members of your family of origin (parents, brothers, sisters, etc.)

Name	Relationship	Age	Occupation/School	Quality of Relationship

Chosen Family: Please list the members of your chosen family or community who are important in your daily life

Name	Relationship	Age	Occupation/School	Quality of Relationship

Whom did you live with mostly when you were a child? (Under age 16)

◯ Biological Parents
◯ Father Only
◯ Mother Only
◯ Foster Care
◯ Other Relative
◯ Parent & Stepparent
◯ Adoptive Parents/Family
◯ Other

During your childhood were you ever injured from the discipline used by your parents? ◯ Yes ◯ No

During your childhood did you ever see your care takers have physical fights with each other? ◯ Yes ◯ No

Were you ever arrested by the police before you turned age 16? ◯ Yes ◯ No

You are currently: ◯ Single ◯ Dating ◯ Engaged ◯ Partnered
◯Domestic Partnership ◯ Married ◯Divorced ◯Widowed

How long?

Do you feel safe in your current relationship? ◯ Yes ◯ No

How satisfied are you with your relationship with your spouse/partner? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

How satisfied are you with your sex life in your current relationship? (circle #)

Extremely Dissatisfied 1 2 3 4 5 6 7 Extremely Satisfied

Previous Relationships/Marriages: ____

Is there a partner from a previous relationship that is making your feel unsafe now? ◯ Yes ◯ No

Do you have any children? ◯ Yes ◯ No

Child #1 - Age:_____ Sex:___________________Gender: ____________________

Child #2 - Age:_____ Sex:___________________Gender: ____________________

Child #3 - Age:_____ Sex:___________________Gender: ____________________

Highest level of education:

Employed? ◯ Yes ______________________________

◯No Position & how long? ______________________________

Religious or spiritual practice or affiliation?______________________________

Please describe your support system: ______________________________

____

____

Hobbies?______________________________

Have you ever been sued? ◯ Yes ◯No Have you ever initiated a lawsuit? ◯ Yes ◯No

(If yes, please explain)

____

____

Medical Information

Primary Healthcare Provider:______________________________Clinic:______________________________

PHP Address: ______________________________

PHP Phone: ______________________________

Last Physical: ______________________________

Current health concerns or illnesses: ______________________________

____

Past illnesses: ______________________________

____

Surgeries: ______________________________

____

Have you ever had a head injury or concussion from a fall, crash, or other kind of accident? ______________________________

____

____

Are you currently taking non psychiatric medications? ◯ Yes ◯No (If yes, please list):

____

____

____

Mental Health History

Have you ever participated in therapy or counseling before? ◯ Yes ◯No

Dates	Provider	What was Helpful/Unhelpful?

Are you currently prescribed any psychiatric medication? ◯ Yes ◯No If yes, are you taking them as prescribed?

____

____

Have you previously been prescribed medication for your nerves, depression, anxiety, sleep, etc? ◯ Yes ◯No

(If yes, please list)

____

____

Have you ever been hospitalized or received inpatient treatment for a mental health condition?
◯ Yes ◯ No (If yes, please list when, where, why)

____
____

Are there members of your family who have been on medication, hospitalized or in some other way treated for a mental health issue? ◯ Yes ◯No (If yes, please explain)

____
____

Substance Abuse

Please describe your caffeine intake:____
Please describe your alcohol use:____
Alcohol use in the past:____
Please describe any current or past drug use including, cocaine, crack, ecstasy, heroin, inhalants, marijuana, methamphetamines, pain killers, PCP/LSD, Steroids, tobacco, tranquilizers or other:

____
____
____
____

Are there members of your family who have had problems with alcohol or drugs? ◯ Yes ◯No
(If yes, please explain)____
____

Legal History

Are you currently or have you been in the past involved in any legal proceedings? ◯ Yes ◯No

If yes, please describe: ____

Have you ever been arrested? ◯ Yes ◯No

If yes, please describe: ____

Expectations

What do you hope to get out of counseling, what would you like to see change?
____
____
____
____

I expect counseling to last_____sessions:

◯ 0-6 sessions ◯ 6-10 sessions ◯ 11-20 sessions ◯ 21-52 sessions ◯ Over 52 sessions

After counseling, I expect the issues I intend to address to be:

◯ No better ◯ Slightly better ◯ Moderately better ◯ Mostly better ◯ Completely better

The pain and distressed caused by what is bringing me in is:

◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe

The pain and distress caused for others by what is bringing me in is:

◯ Very mild ◯ Mild ◯ Moderate ◯ Severe ◯ Very Severe

Thank you for providing me with this important information