

Informed Consent & Confidentiality Agreement

Thank you for taking the time to request counseling services, we understand this is a big step in your journey towards healing and we are excited to work with you. Please read and initial next to each section below indicating you have read about what you can expect from our counseling services, what we expect of our clients, and other important information regarding your care. Please expect to review this information with your counselor at your first appointment.

Our Services

William Temple House offers affordable person-centered and trauma-informed counseling to our community with the support of intern and volunteer counselors. These counselors are either licensed in the state of Oregon or they are under the direct supervision of a counselor who is licensed in the state of Oregon. We strive to provide individualized therapy to our clients, and you can learn more about your therapist – their clinical background and therapeutic approaches in your first session. Our counselors work in a collaborative setting where consultation with supervisors and other counselors is common and encouraged. The practice of consultation ensures safe, ethical, and quality care is being provided to clients while offering therapists educational opportunities. Our counselors must meet certain requirements before they are authorized to practice and are closely supervised in group and individual supervision.

Our Commitment to You

Client Initials

Regular Sessions *We know that counseling is not easy work and in order to help our clients meet their therapeutic goals we do our best to provide consistent, reliable, and predictable services.*

- Your counselor will meet with you for one 50-minute session in a safe and confidential space (via telehealth or in person) each week for approximately 25-50 sessions. If you feel you could address your therapeutic goals in 12 sessions or less, please indicate this on the following Request for Services form. Doing so will inform our team that you are looking for short-term counseling. Short-term counseling may be a good option if you have clarity about your goals, are looking to increase coping skills, have a specific incident to address, or have had a lot of experience with counseling in the past and you feel you only need to check in with a counselor.
- If you are engaging in a *teletherapy* session, you can expect:
 - Your counselor to ask if you are in a safe and private location for the session. If you are not safe or in a private space, we may ask that you move to a different location or reschedule for a time that privacy can be ensured.
 - The counselor will take note of your physical location in the unlikely event that an emergency occurs, and we need to contact outside support. In an emergency, we may reach out to your emergency contact.
 - To make a plan with your therapist in the event of technological failure (bad connection, dropped call, etc.). This plan may involve your counselor reaching out using a different method or resending a link, etc.
 - In situations where it is deemed necessary or requested by the client, the counselor may use a method to ensure they are speaking with the client, such as a password or code word to verify the client's identity and/or indicate it is safe to talk.
 - Please note, if you are receiving teletherapy, you must physically be within Oregon state lines at the time you are receiving services – this is a licensure requirement.
 - We are happy to provide teletherapy services to our clients and we appreciate that people often feel more comfortable receiving services in their home. However, please be sure to treat your tele-therapy session the way you would if you were coming into our office. This means we expect clients to be appropriately clothed, the space they are meeting in be appropriately private (not a public space), clients be focused and present (not completing household tasks, running errands, leaving the space to tend to something in another room, etc.), and that clients refrain from using mood-altering substances during session. If any of these expectations feel difficult for you to maintain for any reason, please bring it up with your counselor and they will help come up with a viable solution.

- If you reach out to us between sessions via phone or email during business hours, we will make every effort to connect with you as soon as your counselor or an appropriate clinical staff is available. If you reach out after hours, we will connect with you the following business day.
- Our current operating business hours are Monday, 9am-5pm and Tuesday-Thursday, 9am-9pm. Our department is closed most major holidays and for two weeks during the December and January holiday season.
- William Temple House's counselors provide regular therapy, but we cannot provide or perform any psychological or psychiatric evaluations or provide medication evaluation or medication management. Should you need an evaluation or request support with medications, your counselor will refer you to someone who can meet that specific need.
- We strive to offer some of the most affordable mental health services in Portland, with fees ranging from \$0-\$80 per session. We trust you to indicate how much you can afford to pay at any given session and ask that you communicate concerns you have about your ability to pay with your counselor. You may pay for your services via PayPal, cash, or check and we request that you submit payment following each session or at any interval of time that makes sense for you financially (i.e. monthly, quarterly, etc.).
- Our interns are often shadowed by licensed supervisors in therapy sessions. The purpose of this is to provide feedback to counselors regarding their approach, style, and engagement with clients and to improve services. Shadowing will often take place by a supervisor sitting in on a session but participating silently and often invisibly. If this makes you uncomfortable or if you are unwilling to have a licensed therapist sit in on your sessions, please indicate this on your Request for Services form.

Client Initials

Waiting List *Due to high demand for our services, we often have a waiting list so it is likely you will not be assigned a counselor right away.*

- Once we receive your request for services, we will communicate with you to let you know that we have processed your request.
- Being on our waiting list does not mean that you are a client. If we do not feel we can serve you, we will try to connect with you and make referrals elsewhere as quickly as possible.
- If you indicate on your request for services that it is okay for us to email you, we will also notify you of any new groups that start while you are on our waiting list.
- Should you experience a mental health crisis while you are on our waiting list you should either: call **9-1-1**, call a crisis line (**Multnomah County Crisis Line: (503) 988-4888**) or go to the **nearest hospital emergency room**.
- We understand that many people are on multiple waiting lists for therapy, and it is completely acceptable for you to be on a few waiting lists at a time. If you start services elsewhere before you get assigned a counselor with us, please call, or email us so we may remove you from our waitlist.
- There is no penalty or consequence for requesting services with us again if you have been on our waitlist before.

Client Initials

Confidentiality *Counseling is confidential and materials about the services you receive will be kept confidential except in cases involving threat or harm to yourself or others.*

- Oregon law requires we report abuse of a child, an elderly person, or a person who has a disability. Child abuse includes physical abuse, sexual abuse or exploitation, and neglect.
- If you were to express intention of serious self-harm or suicide, our counselors will respond as they deem appropriate to help ensure your safety. This may mean completing a safety plan or, if indicated, moving towards hospitalization. A supervisor may become more directly involved in cases of severe suicidality or self-harm.
- If we receive a request for your file from another care or medical provider or for any other purpose, we will reach out to you and try to obtain a signed Release of Information before relinquishing it. However, if your file were to be subpoenaed or court ordered by a judge, we would comply with this directive with or without your consent.

We will notify you of any such court order to allow you an opportunity to take any action in court if you deem appropriate. Any such notification will be sent to your last address on file.

- We will comply with all applicable laws including laws which require us, in certain circumstances related to minors, to report domestic violence that occurs in the presence of a minor.

Client Initials

Your File *Counselors take notes and keep a file on each client or family system they work with. Client files and notes are:*

- Created and used by William Temple House licensed and non-licensed personnel, they are intended to be used by our program as part of day-to-day administrative functions and educational training tools. The files we keep are the property of William Temple House.
- Our files are not intended to be used by clients or third parties for any purpose other than helping to understand and enhance the experience of the client and help them achieve their counseling goals and thus, are not intended to be utilized in any civil, criminal, or administrative proceeding of any kind. Our document retention practices apply to our client files and follow applicable laws.
- Notes for family and partner therapy sessions are kept on one form in one file, as is the accepted standard of practice for family and partner therapists. Due to this practice William Temple House counseling department may be limited in its ability to protect the individual privacy of those named in family notes but every effort to protect your identity and information will be made.

Client Initials

Counselor/Client Boundaries *We want you to know and understand the boundaries we have put in place to protect our clients and our counselors.*

- Counselors are not allowed to meet with you off-site or have any kind of contact with you outside of scheduled counseling services.
- Counselors cannot receive gifts from or offer gifts to clients and may not initiate physical contact with you. If you experience any interaction in which a counselor attempts to initiate physical contact with you, we ask that you immediately notify our Clinical Director.
- If you were to run into your counselor outside of William Temple House, for the sake of confidentiality and your privacy, your counselor will not initiate conversation or indicate they know you. This is not meant to be a personal rejection but simply to protect your confidentiality.
- Counselors will not engage with any client on any social media platform, and we ask that you do not reach out to your counselor on any platform at any time, even after your therapy services have ended.
- Your counselor may contact you with your permission only via phone, email, and text appointment reminders (not direct text).
- It is our practice not to provide therapeutic support via email between sessions though your counselor may email you information in the form of articles, links, and updated paperwork as appropriate and only when you have approved these interactions. Please note that email is not the most confidential form of communication, and all efforts will be made to protect your information; anything you send via email cannot be guaranteed to be confidential.

Client Initials

Attendance *We ask our clients to come to therapy ready to engage and participate in therapy.*

- If you are unable to make your appointment, please call or email to either cancel or reschedule your appointment at least six hours before the scheduled session.
- We will try to reach out via phone or email if you are not present for a scheduled appointment and, if we are concerned about your safety, we may reach out to your emergency contact. We will only do so after alerting you that this is our next step in a voice mail or email.

- If we do not hear from you after at least 3 different communication attempts we may close your file, we will let you know that this has occurred, and you are welcome to reinstate a request for services with us at any time.

Client Initials

Safety *We are dedicated to being a safe place for every member of our community.*

- Our therapists are trained to provide appropriate and trauma-informed counseling to people in all bodies and of all identities. If you feel you are being discriminated against or if you are unhappy with the services, you have been provided, please ask to speak to your counselor's supervisor or our Clinical Director at any time.
- If a client threatens or enacts physical or sexual harm to members of our community (staff, volunteers, interns, or other clients) the proper authorities will be notified.
- If you experience a mental health emergency, please first call either: **9-1-1**, a crisis line (**Multnomah County Crisis Line: (503) 988-4888**) or go to the **nearest hospital emergency room**. Once you are safe, please reach out to our office or to your counselor directly to let them know what has happened.
- Upon completion of this form, please complete a Release of Information for your emergency contact so we may have this on file in the event of an emergency.
- We work hard to provide the highest quality care to our clients, and we understand we cannot meet the needs of everyone requesting our services. If we do not feel we can adequately meet your therapeutic needs, we will work to refer you to someone who is better suited to help you achieve your goals.
- When working with clients experiencing substance use or misuse issues, we operate from a place of harm reduction and ask that you not attend therapy sessions under the influence of substances. If at any time your therapist feels it is unsafe for you or for them to continue a session due to intoxication, they will end the session and consult their supervisor on next steps.
- We want you to feel safe with the person delivering your care. If you have any requests or concerns regarding the counselor that is assigned to you, please indicate this in your Request for Services so we can be sure to assign the most appropriate therapist to you. We cannot always accommodate all requests though we will do our best and may reach out to you to learn more before assigning you a counselor.

By signing below, you are agreeing to the services as they are described above.

Printed Name

Are you seeking in-person or teletherapy services at this time?

☐ In-Person

☐ Teletherapy

Family Counseling If you are requesting family counseling, please list the names of anyone else who will be in your counseling session with you (i.e. partner(s), family members, etc.).

Signature: _____

Date Signed: ____ / ____ / ____

Request for Counseling Services – Adult Client

Thank you for taking the time to complete this form, we are excited to learn more about you and your therapeutic goals. Please complete this to the best of your ability and let us know if you have questions.

Demographic Information *Please be informed that these questions are required for statistical purposes and to help us understand who you are. Your answers will not impact the services you receive.*

Date of Request / /	Date of Birth / /	Counseling Requested (check all) <input type="checkbox"/> Individual <input type="checkbox"/> Partner <input type="checkbox"/> Group <input type="checkbox"/> Family
Last Name	First Name	Middle Initial
Address	City	State
Zip Code & County	Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -	Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -
Email Address		
May we email you? <input type="checkbox"/> Yes <input type="checkbox"/> No	May we leave a voice mail? <input type="checkbox"/> Yes <input type="checkbox"/> No	Emergency Contact Name
Emergency Contact Relationship	Emergency Contact Phone Number <input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work () -	Please initial if, In the event of an emergency, we can contact your emergency contact. <div>Client Initials</div>
Do you have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, which provider do you have?	Do you have mental health benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No
How did you hear about our services or who referred you?		
Gender	Pronouns	Sexual Orientation
Race	Marital Status	What language would you like to receive services in?
How long have you lived in the Portland metro area? _____ Months _____ Years		
Annual family income, pre-tax?	How many people are in your household, including yourself?	Housing situation <input type="checkbox"/> Homeless/outside <input type="checkbox"/> Shelter <input type="checkbox"/> Residential Treatment Facility <input type="checkbox"/> None of the above

Financial Information *Details you share about your current financial circumstances will not determine or affect your eligibility for services with us. We ask for this information to better understand factors that may be impacting your life and wellbeing.*

Please tell us about your current income and financial circumstances. Be sure to include income you receive from non-employment sources such as social security, disability benefits, financial aid, familial support, unemployment benefits, child support, etc.

What kind of work do you typically do and are you currently working?

Counseling Needs & Goals *The information you list here will be used to understand more fully what you are hoping for from your counseling experience, match you with an appropriate counselor, and make sure we can meet your needs.*

Please share a little bit about why you are seeking counseling now – what are you hoping to work on and what do you hope to learn or gain?

In order of importance, please rank the top 5 counseling-related topics you are interested in exploring in therapy by labeling the most important as #1:

- | | | |
|--|--|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Loneliness | <input type="checkbox"/> Challenges with Partner(s) |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Life Transitions | <input type="checkbox"/> Parenting Challenges |
| <input type="checkbox"/> Sleep Issues | <input type="checkbox"/> Building a Better Life | <input type="checkbox"/> Processing Trauma or Abuse |
| <input type="checkbox"/> Health Concerns | <input type="checkbox"/> Managing Daily Stress | <input type="checkbox"/> Increasing Emotional Support |
| <input type="checkbox"/> Eating Patterns & Habits | <input type="checkbox"/> Identity Concerns | <input type="checkbox"/> Increasing Coping Skills |
| <input type="checkbox"/> Career/Education Planning or Challenges | <input type="checkbox"/> Self-acceptance | <input type="checkbox"/> Exploring Triggers |
| <input type="checkbox"/> Substance Use | <input type="checkbox"/> Spirituality | <input type="checkbox"/> Rapid Mood Swings |
| <input type="checkbox"/> Family Concerns | <input type="checkbox"/> Grief & Loss | <input type="checkbox"/> Self-esteem Concerns |
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Urges to Harm Yourself | <input type="checkbox"/> Urges to Harm Others |
| <input type="checkbox"/> Topics not Listed: | <input type="checkbox"/> Finding Meaning in Life | <input type="checkbox"/> Suicidal Thoughts |

Please indicate any preferences regarding the counselor you work with here:

Relationships & Resources Information

Name(s) of people who live with you	Age	Relationship to You	How long have you lived with them?

What are some hobbies, interests, or activities you enjoy?

Who are some supportive people in your life?

What are some skills you feel you have?

Is any member of your family (family of origin or chosen family) or household currently receiving counseling services with us? ☐ Yes ☐ No **If so, who and what is their relationship to you?**

Mental Health Information & History *We understand information in this section is extremely sensitive and may be painful to recount. We are vigilant to protect this information and only ask about history that is necessary to provide you with excellent care. If there is information you do not wish to disclose in this format our clinical staff may reach out to ask you for more information before your first session with a counselor is scheduled. We may have follow-up questions regarding information shared in this section, such follow-up is designed to provide you with the appropriate services. Thank you for your cooperation and understanding.*

Have you ever been in counseling before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what was your experience like? Please select only one: <input type="checkbox"/> Positive <input type="checkbox"/> Somewhat positive <input type="checkbox"/> Neutral <input type="checkbox"/> Somewhat negative <input type="checkbox"/> Negative
Have you ever been diagnosed with a mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please list diagnoses and describe the circumstances surrounding these diagnoses (i.e. who diagnosed you, what was the setting, what year were you diagnosed)? Please also note if you agree or disagree with this assessment.

Do you currently take prescriptions or over-the-counter medications to help manage mental health symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list medication and dosage:	Do you currently have a mental health provider (therapist, psychiatrist, peer supporter, etc.) <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list their names and roles:	Have you ever been hospitalized or in an in-patient facility for a mental health issue? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the facility and approximate dates you were there:
Have you ever attempted suicide? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list the date(s):	Are you currently experiencing suicidal thoughts or have a plan to harm yourself? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have access to a gun? <input type="checkbox"/> Yes <input type="checkbox"/> No

Substance Use Information & History Please describe your current and historical substance use in the table below. If you use a substance as prescribed, please indicate this in the "Method" column.

Substance	Method of Use (oral, smoke, injection, snort, etc.)	Amount Typically Used	Age of First Use	Age of Last Use	Have you used this substance in the last 48 hours?	Have you used this substance in the last 30 days?
Alcohol (ex. Beer, Wine, Liquor)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana (Medical or Recreational)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Opiates (ex. Vicodin, Morphine, OxyContin, Fentanyl, Heroin)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sedatives (ex. Valium, Xanax, Ativan, Barbiturates, Ambien)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stimulants (ex. Amphetamine, Cocaine, Crack, Meth, Ritalin)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hallucinogens (ex. LSD, Mushrooms, DMT, PCP, Ketamine)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Inhalants (ex. Nitrites, Whippets, Paints, Fuels)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Synthetics (ex. K2, Spice)					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Is there any additional information about your substance use that you wish to share with us?

Health Information & History Please list any information you feel is relevant regarding your current physical health. Consider adding information about ailments and illnesses, sleeping issues, eating disturbances or pattern you are concerned about, and information about your physical activity.

Tell us about your current health– are there things you are concerned about?		
Are there aspects of your health that you feel are going particularly well?		
Do you currently take prescriptions or over-the-counter medications to help manage health symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list medication and dosage:	Do you currently have a healthcare provider (primary care, OB/GYN, etc.) that you see regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, please list their names and roles:	Have you ever been hospitalized for a health issue or operation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list the facility and approximate dates you were there:

Availability Please indicate when you are available for counseling by checking all times you are generally available below.

	Monday	Tuesday	Wednesday	Thursday	Friday
Morning (9am-12pm)					
Afternoons (1pm-4pm)					
Evenings (5pm-9pm)					
Our on-site counseling services often take place on the second floor. If you are not able to climb or access stairs, we will be sure to schedule your appointments in an accessible location. Please indicate if you have any accessibility requests or needs here and we will do our very best to accommodate you.					
Are you currently residing in Oregon or Washington? <input type="checkbox"/> Yes <input type="checkbox"/> No			If not, could you physically be in Oregon or Washington during teletherapy sessions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable (Residing in OR or WA)		
Please indicate if you are looking for short-term or long-term counseling: <input type="checkbox"/> Long-Term (25-50 sessions) <input type="checkbox"/> Short-Term (12 sessions or less)					
Please indicate how much you expect you will pay per counseling session: <input type="checkbox"/> \$0 <input type="checkbox"/> \$10 <input type="checkbox"/> \$20 <input type="checkbox"/> \$30 <input type="checkbox"/> \$40 <input type="checkbox"/> \$50 <input type="checkbox"/> \$60 <input type="checkbox"/> \$70 <input type="checkbox"/> \$80					

By signing below, you are stating that the information provided is accurate and true to the best of your knowledge. After we review this information a member of our clinical team may call you to ask for needed follow-up information, please expect this to happen via email or phone call in the next several weeks.

Signature: _____

Date Signed: ____ / ____ / ____