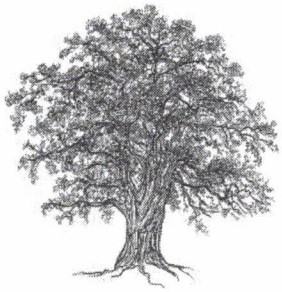

Meristem Counseling Center, LLC

Shawn M. Moling, MA

Philosophy and Approach to Counseling

Counseling is a journey one takes with a therapist in which to seek guidance for the sake of living healthier and more abundantly. In dealing with past traumas, a person may learn to navigate past wounds and identify hurts that have held them back from enjoying a rich, full life. My focus in therapy begins with establishing the therapeutic relationship with my client, including working together to identify and develop goals at the outset of therapy. My philosophy of counseling is based in attachment and psychodynamic theories. I help my clients explore areas of conflict based on expectations of themselves and others that originate in earlier experiences of familial and interpersonal relationships.

I believe that life can be very challenging and difficult at times and people are held back from reaching their true potential by self-inflicted wounds or by the wounds caused by others. As a therapist, I consider issues of physical, emotional, psychological, and spiritual well-being. By working together, through the therapeutic relationship, clients can receive honest feedback while feeling free and safe from judgment. It is through this therapeutic relationship that clients can express what they are processing and grow, heal, and meet their personal life goals.

Additional information concerning myself and my practice is available on the Board's website.

Formal Education and Training

- B. S. Psychology - George Fox University - 2003
- A.A.S. Paralegal - Everest College - 2007
- M.A. Clinical and Mental Health Counseling - Corban University - 2018 (CACREP Accredited)
  Major Course Work: Theories I & II; Internship I & II; Ethics; Testing and Measures; Research; and Counseling and Diversity *(this is not an exhaustive list of courses taken)*

Code of Ethics

As a Licensed Professional Counselor in the State of Oregon, I abide by the Code of Ethics established by the Oregon Board of Licensed Professional Counselors and Therapists (OBLPCT). My Licensed Professional Counselor Number: C7030

Sliding Fee Scale

If you do not have insurance that I am contracted with, you may qualify for sliding scale fee. The sliding scale fee is determined by yearly income and number of family members currently living in the household. All sliding scale fees are discussed with the therapist during the initial session. We accept cash, check, VISA, Master Card, Discover, and American Express.

Yearly Income: $_____

Number of Family Members Currently Living in The House Hold: _____

760 SW Madison Ave., Ste. 107
Corvallis, Oregon 97333
meristemtcounseling@hushmail.com
http://www.meristemcounseling.org

Phone Number: 206.397.6066

Fee Agreement

1. All fees will be decided upon by the end of the first session, based on the above sliding scale.
2. All fees will be payable by the end of each session, unless otherwise negotiated.
3. Since the scheduling of an appointment involves the reservation of time specifically for you, sessions missed without 24 hours' notice will be billed at full charge. If you must cancel an appointment, please call and leave a confidential message, as needed.
4. Any telephone consultation more than ten (10) minutes will be charged on a pro-rated basis of the usual rate.
5. If a client's payment by check is returned due to insufficient funds, the client will be charged a $35.00 fee.
6. Clients may be asked to undergo some diagnostic testing for which additional fees may be required. These will be discussed with the client prior to their use.

Emergency Procedures

In the event of an emergency, please call your local crisis line. In the Corvallis area, this number is 541-766-6844.

Confidentiality

Everything that occurs in my sessions is confidential to anyone outside the therapy room. Exceptions are as follows:

- Extreme emergencies, where either you and/or others are in clear and imminent danger;
- Legal action initiated by a client to the Oregon Board of Licensed Counselors and Therapists;
- Information required in court proceedings or by a client's insurance company, or other relevant agencies;
- Communication revealing that a minor or an elder is, or is suspected to be, the victim of crime, abuse (physical, mental/emotional, or sexual abuse), or neglect; or
- Information shared in the context of clinical consultation.
- Information may be shared with billing agent or insurance company for the purpose of seeking claim reimbursement.

Client Bill of Rights

As a client of an LPC, you have the following rights:

As a client of a LPC, you have the following rights:

- To expect that a LPC has met the qualifications of training and experience required by state law;
- To examine public records maintained by the Board and to have the Board confirm credentials of a LPC;
- To obtain a copy of the Code of Ethics;
- To report complaints to the Board;
- To be informed of the cost of professional services before receiving the services;
- To be assured of privacy and confidentiality while receiving services as defined by rule or law, with the following exceptions: 1) Reporting suspected child abuse; 2) Reporting imminent danger to you or others; 3) Reporting information required in court proceedings or by your insurance company, or other relevant agencies; 4) Providing information concerning licensee case consultation or supervision; and 5) Defending claims brought by you against me; and
- To be free from being the object of discrimination on any basis listed in the Code of Ethics while receiving services.

You may contact the Board of Licensed Professional Counselors and Therapists at:
3218 Pringle Rd SE, #120, Salem, OR 97302-6312 | Telephone: (503) 378-5499
Email: lpct.board@mhra.oregon.gov

Continuing Education

Consent to Treatment

I have read the above information and have had the opportunity to ask questions about it. I understand my rights to privacy and the risks associated with treatment. If there are children involved in treatment, I hereby give my consent for their treatment and affirm that I am the legal guardian with the authority to consent to treatment. I also agree to the payment and billing policies outlined above and accept full responsibility for all fees incurred. I consent to participate in treatment, and I understand that I may refuse services at any time. I am also aware that my counselor may periodically consult with other clinicians regarding client issues. My signature below indicates that I have received a copy of my counselor's Professional Disclosure Statement (PDS) as well as the Notice of Privacy Practices and have read, understand, and agree to abide with the policies outlined in this document, and have been offered copies of these documents for future reference.

_____ _____

Client's Signature Date

_____ _____

Client's Signature Date

_____ _____

Counselor's Signature Date

Meristem Counseling Center, LLC
Shawn M. Moling, MA

In order to help your therapist provide the best care, please complete this form. If you are not sure about any item, or feel uncomfortable answering, please leave that part blank. Answer what you are able, and speak with your therapist about any area of concern.

How did you hear about Meristem Counseling Center, LLC? _____

PERSONAL INFORMATION **TODAY'S DATE:** _____

Name		Age: Birth date:	
Mailing Address City, State, Zip			
Email		Contact me by email?	YES NO
Home phone		Contact me at my home phone?	YES NO
Cell phone		Contact me by cell phone?	YES NO
Vocation(s)			
Job Title(s)			
Employed by			

Please describe your reason for seeking counseling. _____

_____

_____

_____

What do you hope to gain from counseling? _____

_____

_____

Please describe any previous counseling experience(s). _____

_____

Religious Affiliation _____ Involvement: ☐ Active ☐ Somewhat active ☐ Inactive

What are your religious beliefs? _____

_____

What spiritual tradition were you raised in, if any? _____

How do your current spiritual beliefs help you during problematic times in your life? _____

_____

Please indicate your go-to sources for **Emotional or Social Support** (E.G., Church, Social Events, Family, Work, Hobbies, Clubs, etc.): _____

Relationship Status: ☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Long term relationship

How long has this been your relationship status? _____

If in a committed relationship, how would you describe your relationship? _____

_____

Description of Household:

Name	Age	Relationship
Other immediate family members NOT living at home		

If you have **children**, how would you describe your relationship with them? _____

_____

_____

Please describe any **Major Traumas** you have experienced (sudden loss of child or loved one, military combat, feared death experiences, etc.)

_____

_____

_____

Medical Information:

Name of Primary Physician _____ Phone _____ Date of last visit _____

Do you have a **mental health** diagnosis? If so, what is it and when was it diagnosed? _____

_____

Please list all Current Medications:

Name of Medication	Dosage	Times per day (am/pm)	Physician	Reason for

CURRENT CLIENT SYMPTOMS: Please rate ALL from 1-3 (1-no/low concern, 2-moderate concern, 3-high concern)

☐ Family problems	☐ Feel sad or depressed	☐ Anxiety / worry	☐ Hear strange things
☐ Marital / relationship issues	☐ Cry often	☐ Stress	☐ See strange things
☐ Trouble communicating	☐ Feel hopeless	☐ Extreme fear	☐ Wanting to hurt others
☐ Physical or sexual abuse	☐ Anger problems	☐ Panic attacks	☐ Suicidal thoughts
☐ Domestic violence	☐ Frustration	☐ Aggressive behaviors / feelings	☐ Others are out to get me
☐ Sexual problems	☐ Trouble concentrating	☐ Nightmares	☐ Thoughts of death
☐ Intimacy issues	☐ Trouble sleeping	☐ Upset stomach	☐ Wanting to hurt myself
☐ Divorce	☐ Feel guilty	☐ Health problems	☐ Legal problems
☐ Employment changes	☐ Low self-esteem	☐ Severe pain	☐ Financial problems
☐ Grieving	☐ Loss of appetite	☐ Headaches	☐ Smoke cigarettes
☐ Lack of sex drive	☐ Dramatic weight changes	☐ Sweating	☐ Alcohol use
☐ Spiritual issues	☐ Feel tired or low energy	☐ Trouble breathing	☐ Drug use
☐ Can't make friends	☐ Lack of motivation	☐ Quick mood changes	☐ Restless / Can't sit still
☐ Feel lonely	☐ Problems at work	☐ Can't stop thinking	☐ Impulsive
☐ Withdrawn from others	☐ Problems at school	☐ Eating disorder	☐ Other:

Please briefly explain any 2/3 level concerns: _____

Problems that occurred in the HOUSEHOLD(S) in which you were raised BEFORE THE AGE OF 18:

	Alcohol / drug addiction		Physical abuse		Emotional / verbal abuse		Unwanted touching
	Financial problems		Sexual abuse		Divorce		Lived in foster home
	Emotional distance		Pornography				

Problems that occurred TO YOU BEFORE THE AGE OF 18:

	Alcohol / drug addiction		Physical abuse		Emotional / verbal abuse		Unwanted touching
	Financial problems		Sexual abuse		Divorce		Lived in foster home
	Emotional distance		Pornography		Developmental problems		Learning disability

On the following checklists, please mark (√) the problems that are a concern to you.

√	Concerns about YOURSELF	√	Concerns about YOUR PARTNER	√	Concerns about YOUR RELATIONSHIP	√	Concerns about your CHILDREN / FAMILY
	Chronic illness / pain		Chronic illness / pain		Poor Communication		Stealing
	Depression		Depression		Argue about finances		Destructive Behaviors
	Anxiety / worries / stress		Anxiety / worries / stress		Not enough time together		Truancy
	Eating disorder		Eating disorder		Excessive alcohol / drugs		Adolescent pregnancy
	Relationship problems		Relationship problems		Pornography		Sexual abuse (victim)
	Grief		Grief		Refuses sex too often		Sexual abuser
	Self-esteem		Self-esteem		Demands sex too often		Disobedience
	Lack of assertiveness		Lack of assertiveness		Inappropriate sexual behavior		Divorce adjustment
	Suicidal thoughts		Suicidal thoughts		Physical sexual problems		Death in family
	Self-injury / self-mutilation		Self-injury / self-mutilation		Fighting / arguing		Anger / Fighting
	Anger		Anger		Parenting issues		Drugs / alcohol
	Sexual addiction		Sexual addiction		Partner too controlling		Peer relationships
	Sexual abuse / rape		Sexual abuse / rape		Physical violence		Bed-wetting / soiling
	Emotional abuse		Emotional abuse		Difficulties with in-laws / family		Poor self-esteem
	Physical abuse		Physical abuse		Different values		Issues with stepchildren
	Other:		Other:		Other:		Other:

Understanding your "family system" can be very helpful in getting to the root of problems or concerns that you are facing. To the best of your knowledge, please mark (√) where appropriate and give any details you know.

History of...	Self	Spouse	Immediate Family	Extended Family	Details
Significant medical concerns					
Mental health concerns					
Military service					
Abuse					
Alcohol / Drug use					
Alcohol / Drug misuse					
Addictions					
Pornography use					
Affair(s)					
Trouble with the law					
Divorce / Separation					
Other:					

Any other situation, experience, or concern your therapist should be aware of? _____

_____

Meristem Counseling Center, LLC
760 SW Madison Ave., Ste. 107
Corvallis, Oregon 97333

MISSED APPOINTMENTPOLICY

Please be advised that a client is **ONLY** allowed to miss **TWO** scheduled appointments. The appointments can either be a combination of a cancellation or a no-show. **TWO** missed appointments could result in termination of counseling services for a period of one year or indefinitely pending counselor's assessment of treatment and situation. If a person is more than **15 minutes** late for a scheduled appointment without calling, that will be considered a "NO-SHOW."

A "cancelled" appointment is when the client calls (24-hours) ahead of the scheduled appointment in order to let the counselor know that the client is unable to attend the scheduled appointment.

A "no-show" is a person who misses an appointment without calling to cancel their appointment. No-shows inconvenience the counselors as well as those who are in need of counseling. **No-shows are billed at the hourly rate.**

HOW TO CANCEL AN APPOINTMENT

To cancel an appointment, please call 206.397.6066 as soon as it becomes apparent that the scheduled appointment will be missed. **Late cancellations will be billed at the hourly rate.**

LENGTH OF SERVICES

Please be advised that the approximate length of services provided will be 30 weeks. As the client nears the 30 weeks, the counselor will reassess treatment at that time.

COURT PROCEEDING AND MEDICATION

Due to registered intern status, we cannot attend court proceedings or prescribe medications.

_____ _____

Counselor Date Client Date

Notice of Privacy Practices

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

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operation 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 another psychologist.
  - Payment is when I obtain reimbursement for your healthcare.
  - 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.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, 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 the PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

III. Uses and Disclosure with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse: If there is a child abuse investigation, I may be compelled to turn over your relevant records.
2. Adult and Domestic Abuse: If there is an elder abuse or domestic violence investigation, I may be compelled to turn over your relevant records.
3. Health Oversight: The Oregon State Board of Professional Counselors and Therapists may subpoena relevant records from me should I be the subject of a complaint.
4. Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law, and I must not release your information without written authorization by you or your personal or legally-appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

5. 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 must limit disclosure of the otherwise confidential information to only those persons and only that content with would be consistent with the standards of the profession in addressing such problems.
6. Worker's Compensation: If you file a worker's 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.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

1. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
2. 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, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
3. Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
4. Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
5. Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
6. 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.

Therapist's Duties:

1. 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.
2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
3. If I revise my policies and procedures, I will provide written notice of any and all revisions.

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 right, you may discuss them with me at any time.

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 regular mailing address.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date and Changes to Privacy Policy

This notice will go into effect on March 26, 2015. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If/when such changes are made; I will provide you with a revised notice in writing at least 30 days prior to the effected change(s).

Meristem Counseling Center, LLC
760 SW Madison Ave., Suite 107
Corvallis, Oregon 97333

Shawn M. Moling, MA, LPC

Credit / Debit Card Payment Consent Form

Client Name: _____

Name on Card: _____

Credit Card Number: _____

Expiration Date: _____

CVV Code; Back of Card: _____

Zip Code (affiliated with billing address): _____

Client Billing Address: **Street:** _____

City: _____ **State:** _____

Zip Code: _____

I authorize Meristem Counseling Center, LLC, or Shawn M. Moling, LPC-Registered Intern, or third party as assigned to charge my credit/debit/health account card for professional services rendered. It is my understanding that if I have provided valid insurance information, this office will first bill the insurance(s) for assignment of benefits, with the exception of office co-pay which may be paid on the date of service, and charges incurred as a result of no-shows, late cancellations, or checks returned due to insufficient funds – in accordance with office policies. I further understand, that client balances evident after insurance(s) response is received will be charged to the card I provide.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied.

Signature: _____

Printed Name: _____ Date: _____