sonja straub

Sonja Straub, Ph.D.
325 N W 21st Ave. Portland, OR 97209
sonja@sonjastraub.com
503 727 2456

CLIENT INFORMATION

Client's Name_____

Address_____

City_____Zip_____

Email address_____

Is it okay to send my messages to this address?_____

Phone Home:_____Work:_____Cell:_____

Can I call and leave messages on home ph_____cell ph_____?

Date of Birth_____

Employer/School Name & Address_____

_____

_____

Who referred you? _____May they be thanked?__

Person who can be contacted in case of emergency? _____

_____

Phone_____Relationship to client_____

INSURANCE INFORMATION

Insurance Name:_____

Address_____

City_____Zip_____

Phone_____

Identification #_____

Group # _____

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Deductible Amount $_____Met? _____no _____yes

Amount of Co-pay $_____

Some insurance require that you get prior authorization. It is your responsibility to let them know that you are coming to see me prior to our first session. You might also inquire what your co-pay will be.

Authorization # if required_____

Who is the Insured? Me___ or _____

If not you:

Date of Birth of Insured _____

Insured's Social Security _____

Insured's address_____

City_____Zip_____

Employer of Insured_____

Client's relationship to the insured? _____

Dr. Sonja Straub has my permission to bill my insurance. I authorize her to release any information necessary to process my claims.
I further authorize that my insurance benefits be paid directly to Dr. Sonja Straub

Client's signature_____Date_____

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CONFIDENTIALITY

Without your permission I am by law not permitted to disclose to anyone anything you tell me, nor even that you come to see me. There are a few exceptions though where I might be required to break confidentiality:

1. If you are in danger to hurt either yourself or somebody else.
2. In cases of ongoing child, elder or disabled abuse.
3. If ordered by court subpoena.
4. I may have to release clinical information to your insurance for payment.
5. On occasion psychologists consult with colleagues; anything mentioned will be without names or identifying information.
6. Denise Beard is handling my billing. I am sharing the necessary information with her. She is held to the same confidentiality rules.

PROCESS WORK METHOD

There are many different kinds of therapeutic methods. I am trained in Process Work, a method that will work to increase your personal awareness. I will work with your personal and individual experiences and with my interventions help you to unfold those deeply. This will lead to new insights and attitudes. At times the methods seem unusual or not make immediate sense. If at any time you have questions about what is happening or feel uncomfortable, please let me know. You are in charge at all times.

CANCELLATIONS

Please try to avoid canceling a scheduled appointment. If you must cancel, you will not be charged for the appointment if you notify me **24 hours in advance**. Otherwise you will be charged in full; insurances do not cover missed sessions. Please sign to confirm that you understood and agree to this:

Signature _____

Date_____

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SOME INFORMATION ABOUT YOU

Present medical or physical problems? _____

_____

Present medications (including dosage) _____

_____

What kind and how much alcohol do you drink? Any other drug use?

_____

_____

Any prior counseling experience?_____

What brings you into counseling today? _____

_____

ACKNOWLEDGEMENT OF RECEIPT

of 'NOTICE OF PRIVACY PRACTICE' & 'OFFICE POLICIES & GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES'

I, _____ , have received the above mentioned documents.

Client name:

Signature: _____ Date: _____

It is your right to refuse to sign this document.