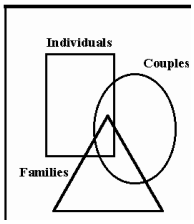


MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
Licensed Professional Counselor
National Certified Counselor

1335 Cannon Street, SE
Salem, Oregon 97302
Phone: 503-375-6362
Fax: 503-581-6046
mg@martingay.com
www.martingay.com

COUNSELING FEES

My regular fees (and when billing insurance) are:

Initial Session (50 Min.) $150.00

Individual/Couple/Family Session (50 Min.) $100.00

Late Cancellation/Missed Appointment Fee $60.00
This fee will be charged for missed appointments and cancellations without 24 hours notice.

As a courtesy, I will bill your insurance company or third-party payer for you. **In the event that the claims are denied, it is the client's responsibility to pay the balance due.**

I offer a **sliding fee**, based on household income and number of people in the household, to those clients or families experiencing financial hardship. If you have a concern, please mention it. The sliding fee can not be used if you want me to bill your insurance.

Sliding Fee: $_____ per session. **Please make arrangements to pay at time of session.**

REQUEST FOR TREATMENT

I am requesting treatment for myself and/or_____ from Martin J. Gay, M.S. I AGREE TO THE ABOVE PAYMENT CONTRACT AND AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SESSIONS INCLUDING ANY SCHEDULED APPOINTMENT MISSED OR CANCELED WITHOUT 24 HOUR NOTICE. In case of illness, please contact me (or leave a message) by 8:00 A.M. There will be no charge for same day cancellations due to illness.

I understand that everything I say in counseling will be kept confidential, with the following exceptions:

1. I direct the therapist to tell someone else.

2. I reveal the intent to commit a crime or other harmful act that poses a clear and immediate danger to myself, others, or society.

3. I reveal abuse to a child or elder (including physical, sexual, and sever emotional abuse or neglect). I understand that the therapist is required by law to report child abuse to the Children's Services Division. The therapist is also required to report injury or neglect of a person sixty-five years of age or older to the Oregon Senior Services Division or to law enforcement. I also understand that the therapist will always talk honestly with me and/or my family to check out the situation before reporting.

CLIENT'S ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have read and received a copy of the Notice of Privacy Practices of Martin J. Gay, MS, LPC, NCC, effective 11/21/2006.

NAME OF CLIENT: _____ BIRTH DATE: _____

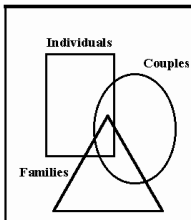
SIGNATURE OF CLIENT: _____ DATE: _____

NAME OF CLIENT: _____ BIRTH DATE: _____

SIGNATURE OF CLIENT: _____ DATE: _____

Relationship to Client (if signed by Personal Representative): _____

THERAPIST:_____ DATE:_____



MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
Licensed Professional Counselor
National Certified Counselor

1335 Cannon Street, SE
Salem, Oregon 97302
Phone: 503-375-6362
Fax: 503-581-6046
mg@martingay.com
www.martingay.com

INSURANCE INFORMATION FORM

CLIENTS NAME:_____

PRIMARY INSURANCE:

Client's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other ☐None

INSURED'S NAME:_____ _____
(If other then Self - First, Middle Initial, Last) (Date of Birth)

ADDRESS:_____
(No., Street)

_____
(City, State, ZIP)

Gender: ☐Male ☐Female

Employer:_____

Insurance Company:_____

Address:_____
(No., Street)

_____
(City, State, ZIP)

Phone:_____

Insured's ID Number:_____

Policy Group Number:_____

Prior Authorization Number (if required):_____

Deductible Amount:_____ Percent covered by insurance:_____

Anniversary date of coverage (date deductible begins again):_____

SECONDARY INSURANCE:

Client's Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other ☐None

INSURED'S NAME:_____ _____
(If other then Self - First, Middle Initial, Last) (Date of Birth)

ADDRESS:_____
(No., Street)

_____
(City, State, ZIP)

Gender: ☐Male ☐Female

Employer:_____

Insurance Company:_____

Address:_____
(No., Street)

_____
(City, State, ZIP)

Phone:_____

Insured's ID Number:_____

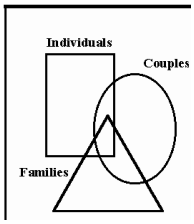
Policy Group Number:_____

Deductible Amount:_____ Percent covered by insurance:_____

Anniversary date of coverage (date deductible begins again):_____

Most insurance companies will pay part of my fee. As a courtesy, I will bill your insurance company or third-party payer for you. In the event that the claims are denied, it is the client's responsibility to pay the balance due. **Your signature below authorizes direct payment to Martin J. Gay, MS, and the sharing of any and all information (including any and all chart notes) needed to process your claims with your insurance company. Martin J. Gay, MS cannot be held responsible for how insurance companies may use such information. The above named client will receive a mental health (psychiatric) diagnosis used to meet insurance and state requirements.**

Signature_____ Date_____



MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
Licensed Professional Counselor
National Certified Counselor

1335 Cannon Street, SE
Salem, Oregon 97302
Phone: 503-375-6362
Fax: 503-581-6046
mg@martingay.com
www.martingay.com

PERSONAL, FAMILY & RELATIONSHIP INFORMATION

Please fill out the following information as completely as possible:

Today's Date_____

CLIENT'S NAME:_____ _____
(First, Middle Initial, Last) (Date of Birth)

ADDRESS:_____ _____
(No., Street) (Age)

_____
(City, State, ZIP)

How would you like me to contact you? (Please circle response)

Home:	yes or no	Phone:
Work:	yes or no	Phone:
Cell phone:	yes or no	Phone:
Email:	yes or no	Email address:
Other:		

STATUS:

Marital:	☐Single	☐Married	☐Divorced	☐Widowed
Employment:	☐Full-Time	☐Part-Time	☐Not-Employed	
Student:	☐Full-Time	☐Part-Time	☐Non-Student	

May I thank someone for referring you to my office?:_____

HOUSEHOLD INFORMATION (Please list others living in the household & relationship to client):

NAME:_____ ☐M/☐F Age_____ Date of Birth_____
(& Relationship)
NAME:_____ ☐M/☐F Age_____ Date of Birth_____

NAME:_____ ☐M/☐F Age_____ Date of Birth_____

NAME:_____ ☐M/☐F Age_____ Date of Birth_____

NAME:_____ ☐M/☐F Age_____ Date of Birth_____

NAME:_____ ☐M/☐F Age_____ Date of Birth_____

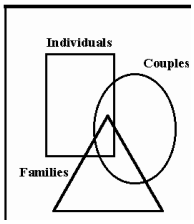
NAME:_____ ☐M/☐F Age_____ Date of Birth_____

Family Physician:_____

Other Agencies involved with family:_____

Reason for requesting help:_____

_____



MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
Licensed Professional Counselor
National Certified Counselor

1335 Cannon Street, SE
Salem, Oregon 97302
Phone: 503-375-6362
Fax: 503-581-6046
mg@martingay.com
www.martingay.com

INSTRUCTIONS: To assist me in helping you, please fill out this form as fully and openly as possible. If certain questions do not apply to you, are too difficult to answer, or seem objectionable, leave them blank. I will assist you with this portion at the first session if you wish.

CONCERNS/PROBLEMS IDENTIFIED (Use initials of family member, check all that apply):

- ☐ Anger Management
- ☐ Antisocial/Aggressive Behavior
- ☐ Anxiety
- ☐ Attention-Deficit/Hyperactivity Disorder
  - ☐ Diagnosed
- ☐ Autism
- ☐ Chemical/Substance Dependence
  - ☐ Adult ☐ Child
  - ☐ Relapse
- ☐ Childhood Traumas
- ☐ Conduct Problems/Delinquency
- ☐ Dependency
- ☐ Depression
- ☐ Developmental Disorder
- ☐ Eating Disorder
- ☐ Educational Deficits
- ☐ Victim of Emotional Abuse
- ☐ Enuresis/Encopresis (inability to control bladder or bowels)
- ☐ Family Conflicts
- ☐ Financial Problems
- ☐ Fire Setting
- ☐ Gender Issues
- ☐ Unresolved Grief or Loss
- ☐ Impulse Control Problem
- ☐ Intimate Relationship Conflicts
- ☐ Learning Disorder/ Underachievement
- ☐ Legal Conflicts
- ☐ Low Self-Esteem
- ☐ Medical Issues
- ☐ Obsessive-Compulsive Behaviors
- ☐ Oppositional Behavior
- ☐ Chronic Pain
- ☐ Panic Attacks
- ☐ Parenting Problems
- ☐ Teen Parent
- ☐ Parent Suffers Mental Illness
- ☐ Peer/Sibling Conflict
- ☐ Phobia
- ☐ Victim of Physical Abuse
- ☐ Racial/Cultural Problems
- ☐ Runaway
- ☐ Refuses to go to School
- ☐ Victim of Sexual Abuse
- ☐ Inappropriate Sexual Behavior
- ☐ Sexual Abuse Perpetrator
- ☐ Sexual Dysfunction
  - ☐ Male ☐ Female
- ☐ Sleep Disturbance
- ☐ Social Discomfort/Shyness
- ☐ Speech/Language Disorders
- ☐ Spiritual Confusion
- ☐ Thoughts/Attempts of Suicide
- ☐ Vocational, Career, or Job Stress

PLEASE MAKE NOTE OF ANY OTHER COMMENTS THAT YOU FEEL ARE IMPORTANT TO THIS COUNSELING PROCESS:

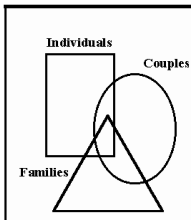
_____

_____

_____

FAMILY AND INTERPERSONAL HISTORY:
(Include information <u>such as</u> the following.)
Place of birth:
Number and order of siblings:
Raised by both parents?:
How did parents get along?:
If adopted:
    What circumstances?:
    Adopted by relatives?:
Sociable as child?:
Other adults/children in childhood home?:

LIFE AS AN ADULT:
Living situation:
    Currently with whom?:
    Where?:
Finances:
Ever homeless?:
Support network:
    Family ties:
    Other agencies:



MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
Licensed Professional Counselor
National Certified Counselor

1335 Cannon Street, SE
Salem, Oregon 97302
Phone: 503-375-6362
Fax: 503-581-6046
mg@martingay.com
www.martingay.com

Marital:
- Number of marriages:
- Age at each:
- Problems with spouse?:

Number of children, age, and sex:
Stepchildren?:
Religion:
- Which:
- Different from childhood:
- How religious now:

Leisure activities:
- Clubs, organizations:
- Hobbies, interests:

Sexual preference and adjustment:
- Learning about sex: details:
- First sexual experiences:
  - Nature:
  - Age:
  - Reaction:
- Current sexual problems:
- Abuse:
  - Childhood molestation:
  - Rape:
  - Spouse abuse:

Other:

PSYCHOLOGICAL AND PSYCHIATRIC HISTORY:
Past counseling:
- With who:
- Approximate dates:

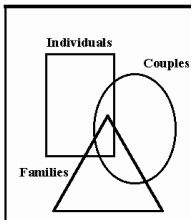
Past mental illnesses diagnosed:
Medications for mental problems:
- Dose:
- Frequency:
- Side effects:

Mental hospitalizations:
Mental disorder in close relatives:
Suicide attempts:
Other:

MEDICAL HISTORY:
Health as a child:
Major Illnesses:
Operations:
Last physical exam:
Medications for non-mental problems:
- Dose:
- Frequency:
- Side effects:

Allergies:
- To environment:
- To medications:

Non-mental hospitalizations:



MARTIN J. GAY, MS, LPC, NCC

Individual, Marriage, Family & Adolescent Therapy
Licensed Professional Counselor
National Certified Counselor

1335 Cannon Street, SE
Salem, Oregon 97302
Phone: 503-375-6362
Fax: 503-581-6046
mg@martingay.com
www.martingay.com

Risk factor for AIDS?:
Physical impairments:
Other:

ALCOHOL AND DRUG USE HISTORY:
Type of substance (include nicotine):
Years in use:
Quantity:
Consequences:
- Medical problems:
- Loss of control:
- Personal or interpersonal:
- Job:
- Legal:
- Financial:

Other:

EDUCATION, EMPLOYMENT, AND VOCATIONAL HISTORY:
EDUCATION:
Last grade completed:
Scholastic problems?:
Activity level?:
- Behavior problems in school?:
- Suspension or expulsions?:

Sociable as child?:

WORK HISTORY:
Current occupation:
Number of jobs lifetime:
Reasons for job changes:
Ever fired? Why?:
Other:

MILITARY:
Branch, years of service:
Highest rank attained:
Disciplinary problems?:
Combat experience?:
Other:

LEGAL HISTORY:
Legal problems ever?:
- Civil:
- History of violent behavior:
- Arrests:

Other: