

## *Elsbeth Martindale, Psy.D.*

5525 E. Burnside  
Portland, OR 97215  
Phone (503)236-0855 FAX (503)233-4449

### **Scheduling Your First Appointment**

The wait time to become a new client is dependent on a variety of factors. Availability of appointment times on our end as well as yours seems the most critical. The more available you are in terms of daytime hours the sooner we can get you started. Many clients prefer after work or school and, as a result, these are the times most difficult to schedule. If you have flexibility in your schedule you will likely increase your odds of getting an appointment sooner.

Our office is currently open four days each week. Please let us know your preferred times for scheduling using the form below. Send this in to our office along with the following forms. We will call you when our appointment times match your availability.

If you don't want to wait to begin therapy, we can suggest several excellent therapists who may have current openings. Please feel free to call to get referral names.

Please return the following:

- Client Information Questionnaire
- Current Symptoms
- Informed Consent for Treatment - sign the back
- Insurance Information
- Schedule on the next page with preferred times marked

Our office is in an old Victorian Home on East Burnside. This is a busy street. We suggest that you park on a side street and walk, although you may park in front of the house except between 7:00 and 9:00 AM. The QFC parking lot is reserved for their patrons.

If you need wheelchair access, please let us know this in advance. We have a ramp, in the back of the office, for those who may have difficulties with stairs. Dr. Martindale's office is on the second floor but arrangements can be made to meet in a ground floor office. Please tell us about your needs so we can make necessary accommodations.

We look forward to seeing you soon,

Linda Berkemeier  
Office Manager

Elsbeth Martindale  
Clinical Psychologist

## Schedule Information

Please return this page so we can know your schedule.

Name \_\_\_\_\_ Date \_\_\_\_\_

Times I am available to schedule an appointment.

Preferred times for appointments mark with ✓  
Available times mark with ✕

### Monday

- 10:00-12:00 AM
- 1:00-3:00 PM
- 4:00-5:00 PM

### Wednesday

- 10:00-12:00 AM
- 1:00-2:00 PM
- 3:00-5:00 PM
- 5:30-7:00 PM

### Thursday

- 10:00-12:00 AM
- 1:00-3:00 PM
- 3:00-5:00 PM

### Friday

- 10:00-12:00 AM
- 1:00-3:00 PM
- 4:00-5:00 PM

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## **INFORMED CONSENT FOR TREATMENT/ CONFIDENTIALITY**

As a client, you have rights and responsibilities when you seek my consultation, including:

1. **THE RIGHT OF CLIENTS TO REFUSE TREATMENT.** You have the right to request a change of therapy, be referred to another therapist, or discontinue therapy at any time. If you are unhappy with therapy or have questions about the treatment, please speak with me about these concerns. If my services are not meeting your needs, I will be happy to refer you to another practitioner.

2. **THE RESPONSIBILITY OF THE CLIENT FOR CHOOSING THE PROVIDER AND TREATMENT MODALITY WHICH BEST SUITS HER/HIS NEEDS.** I will make an assessment and suggest possible treatment modes that may be helpful to you. However, the choice of treatment mode remains with you. If at any time you feel dissatisfied with the therapy, your questions and concerns must be addressed before we can continue.

3. **THE EXTENT OF CONFIDENTIALITY PROVIDED BY LAW.** Under Oregon state law psychologists have an obligation to honor client confidentiality. Nothing you tell me can be told to anyone else without your permission. **HOWEVER, THERE ARE EXCEPTIONS, SOME OF WHICH ARE:**

- **CHILD ABUSE** - I am required to report any known or suspected child abuse to the Department of Human Services.
- **HARM TO ANOTHER** - If I believe a client is about to harm another person, I have a duty to warn and, insofar as possible, to protect the intended victim.
- **SUICIDE** - If I believe someone is immediately likely to harm her/him self, I will try to protect the person by notifying a family member, the police, or the Mental Health Department.
- **EVALUATIONS** - If you meet with me for an evaluation requested by another professional (i.e. counselor, lawyer, or physician), I will routinely send a written report of my findings to that professional. I will obtain a written consent from you in advance authorizing me to make such a disclosure.
- **COLLECTION PROBLEMS** - If you do not pay for services rendered, I may refer your account to a collection agency or file a small claims court suit. Although no clinical information will be revealed, your name, address, dates and fees of service will be released, along with other information that may help make collection possible.
- **FAX** - Our office occasionally uses a FAX machine to transmit information. If personal and confidential information is sent, we make it a priority to insist on the confidentiality of the material to the person receiving the FAX. Our fax number is 503-233-4449.

## **FEES/ ADDITIONAL CHARGES/ BILLINGS/ OFFICE POLICIES PROFESSIONAL FEES**

My fees are based on the amount of professional time spent or reserved. The initial diagnostic interview evaluation fee is \$200. This is charged for your first appointment or upon returning to therapy after a two year absence. The basic fee for subsequent 45 minutes of psychotherapy is \$150 for individual and \$175 for family. Group psychotherapy (1 and 1/2 hours) is \$75 a session. Additional time for phone calls, preparing letters, conferring with other professionals, etc. will be prorated at \$150/hour. Psychological assessments, testing,

Client's Initials \_\_\_\_\_

and/or questionnaires are priced individually. Fees may increase during the course of treatment. If so, you will be notified in writing 30 days in advance.

**ADDITIONAL CHARGES** - You will also be charged for the following. Each charge is payable immediately upon demand.

- \$15 for any check submitted to us to pay any sums for which you are obligated and which check is dishonored.
- A delinquency fee of \$25 in the event you fail to timely pay us any sum you owe and we elect to institute or turn your debt over to a collection agency for collection. If we initiate a collection action and prevail, we will also seek such reasonable attorney fees as the court allows.
- \$85 should you fail to keep an appointment and fail to give us 24 hours advance notice that you will not keep such appointment.
- Phone sessions are available (\$95) but insurance can not be billed for this service.

**BILLINGS** - We request that you pay for your portion of services at the time of your session unless you either:

- request that we will bill your insurance carrier (both primary and secondary, if applicable), which we will do, at the end of your session if you provide us with complete and accurate information (including address of carrier) as we may request on our forms as we deem necessary; or
- request we bill you monthly, in which case the bill is due and is payable immediately upon demand. There is a \$5 service fee for billing which we will add to your charges that we billed.

**MISSED APPOINTMENTS** - The time scheduled for you is reserved exclusively for you. If you do not keep the appointment, no one else will be able to use the time. Therefore, we ask that you please give us 24 hours notice if you need to cancel an appointment. In all events, please call as soon as you know that you will not be able to keep a scheduled appointment. Our voice mail is accessible at all hours.

**EMERGENCIES**- Should you find yourself in need of emergency assistance during hours when our office is closed, call **my home office at 503-234-6577**. If I am not available, you may call the **Crisis Line at 503-988-4888** 24 hours a day or your local emergency room.

#### **MY TRAINING, BACKGROUND AND ORIENTATION-**

I earned my B.A. in Psychology from Westmont College and a Master's degree in Marriage, Family, Child Therapy from Pepperdine University. In 1987, I graduated from Rosemead Graduate School in Southern California with a doctorate in Clinical Psychology. I am currently licensed by the State of Oregon as a Psychologist. To continue my growth and education, I complete a minimum of 25 hours a year of continuing education credit, as required by the Oregon Licensing Board. I operate from an existential theoretical orientation, which essentially means I am concerned with issues of personal meaning, life experience, and self responsibility. Please do not hesitate to ask me about any of my policies, beliefs, or my psychological orientation.

I, \_\_\_\_\_, HAVE READ AND UNDERSTOOD ALL THE FOREGOING AND AGREE TO BE BOUND TO ALL OF THE PROVISIONS REGARDING CONSENT, CONFIDENTIALITY, FEES, CHARGES AND BILLINGS.

\_\_\_\_\_  
Signature of client or legal guardian

\_\_\_\_\_  
Date

# Elsbeth Martindale, Psy.D.

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Client name \_\_\_\_\_ Date of birth \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION

Name of Insured \_\_\_\_\_  Self  Spouse  Parent  Other

Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Address \_\_\_\_\_

Group # \_\_\_\_\_ Identification # \_\_\_\_\_

Effective date \_\_\_\_\_ D.O.B. of insured (if not client) \_\_\_\_\_



Mental health benefits often differ from medical benefits in terms of preauthorization, copay, and billing address. Please call your insurance carrier to obtain answers to the following questions.

Mental Health Insurance Carrier \_\_\_\_\_

Insurance Address \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Deductible Amount \_\_\_\_\_ Met?  Yes  No Copay per Visit \_\_\_\_\_

Preauthorization required?  No  Yes If yes, # of sessions authorized? \_\_\_\_\_

Maximum # sessions/year? \_\_\_\_\_ Maximum \$ amount/year? \_\_\_\_\_

Mental health benefit available:  All  Part \$ \_\_\_\_\_

**Do you have secondary insurance coverage?**  Yes  No

If "yes" please provide the above information for secondary carrier using the back of this form.

### Please read and sign

We bill insurance as a service to you. We are not responsible for assuring that you have initial or ongoing coverage. If your coverage or authorization expires, for any reason, we will hold you responsible for payment. Please keep abreast of your coverage maximum.

I understand the insurance policy of Mt. Tabor Psychological Services, and I authorize Dr. Martindale to provide requested information regarding my treatment to my insurance carrier(s). I also authorize my insurance carrier to assign benefits directly to Dr. Martindale. I have called my mental health insurance carrier to verify coverage and obtain needed authorization.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## **CHILD INFORMATION QUESTIONNAIRE**

Welcome to our office. Please complete the following questionnaire which will be helpful in planning our services for you. If you need clarification or assistance please do not hesitate to ask.

### CLIENT INFORMATION

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_  
Age \_\_\_\_\_ Birth Date \_\_\_\_\_  
Religious Preference: \_\_\_\_\_  Active  Inactive  
School \_\_\_\_\_ Education Level \_\_\_\_\_

### PARENT OR GUARDIAN INFORMATION

Mo. Name \_\_\_\_\_ Fa. Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: Home \_\_\_\_\_ Work \_\_\_\_\_ Phone: Home \_\_\_\_\_ Work \_\_\_\_\_  
Cell \_\_\_\_\_ Fax \_\_\_\_\_ Cell \_\_\_\_\_ Fax \_\_\_\_\_  
Employer \_\_\_\_\_ Employer \_\_\_\_\_  
SS# \_\_\_\_\_ SS# \_\_\_\_\_  
DOB \_\_\_\_\_ Drivers Lic.# \_\_\_\_\_ DOB \_\_\_\_\_ Drivers Lic.# \_\_\_\_\_

List members of your family and all others living in your home:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Occupation</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who suggested you contact us? \_\_\_\_\_  
Name of person to contact in case of emergency \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Has your child ever received psychiatric or psychological help of any kind before?  yes  no

Therapist Dates Purpose Was it helpful?

\_\_\_\_\_  yes  no

\_\_\_\_\_  yes  no

\_\_\_\_\_  yes  no

\_\_\_\_\_  yes  no

Who is the child's primary care physician? \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of child's last physical: \_\_\_\_\_

It is our policy to inform your physician that your child is receiving psychological care. This is for the purpose of coordinating treatment. May I notify your physician about the issues for which your child is seeking psychotherapy?  yes  no Please initial \_\_\_\_\_

List major health concerns for which your child is currently receiving treatment:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies or adverse reactions to medication or treatment: \_\_\_\_\_

List any medications your child is currently taking:

<u>Name of medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Prescribed by</u>	<u>Start Date</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Unusual prenatal or perinatal events: \_\_\_\_\_

\_\_\_\_\_

Developmental delays or concerns: \_\_\_\_\_

\_\_\_\_\_

Explain any abnormalities or concerns regarding; physical, psychological, social, intellectual, or academic development: \_\_\_\_\_

Briefly describe their reason for seeking help: \_\_\_\_\_

\_\_\_\_\_

## Current Symptoms

Please **circle the number** to rate the following symptoms according to the degree to which they are troubling your child's life. Also, **in the blank**, indicate **how long** these problems have been present.

Scale	1=extremely big problem	6= little or no concern
MOOD	1 2 3 4 5 6 _____	Communicating 1 2 3 4 5 6 _____
Tiredness	1 2 3 4 5 6 _____	IMPULSE Control 1 2 3 4 5 6 _____
Inferiority Feelings	1 2 3 4 5 6 _____	Anger 1 2 3 4 5 6 _____
Concentration	1 2 3 4 5 6 _____	Temper 1 2 3 4 5 6 _____
Appetite	1 2 3 4 5 6 _____	Defiance 1 2 3 4 5 6 _____
Weight Gain/Loss	1 2 3 4 5 6 _____	Argumentative 1 2 3 4 5 6 _____
amount in last month	_____	Hurting others 1 2 3 4 5 6 _____
Sleep	1 2 3 4 5 6 _____	Hurting self 1 2 3 4 5 6 _____
Nightmares	1 2 3 4 5 6 _____	Dangerous behavior 1 2 3 4 5 6 _____
Insomnia	1 2 3 4 5 6 _____	Hyperactivity 1 2 3 4 5 6 _____
Ambition	1 2 3 4 5 6 _____	Medication _____
Unhappiness	1 2 3 4 5 6 _____	SUBSTANCE USE 1 2 3 4 5 6 _____
Irritability	1 2 3 4 5 6 _____	Alcohol 1 2 3 4 5 6 _____
Depression	1 2 3 4 5 6 _____	Drugs 1 2 3 4 5 6 _____
Manic Behavior	1 2 3 4 5 6 _____	Caffeine 1 2 3 4 5 6 _____
Suicidal Thoughts	1 2 3 4 5 6 _____	RELATIONSHIPS 1 2 3 4 5 6 _____
ANXIETY	1 2 3 4 5 6 _____	Separation/Divorce 1 2 3 4 5 6 _____
Nervousness	1 2 3 4 5 6 _____	Friends 1 2 3 4 5 6 _____
Panic Attacks	1 2 3 4 5 6 _____	Siblings 1 2 3 4 5 6 _____
Compulsive Behavior	1 2 3 4 5 6 _____	Shyness 1 2 3 4 5 6 _____
Obsessive Thoughts	1 2 3 4 5 6 _____	Loneliness 1 2 3 4 5 6 _____
Fears	1 2 3 4 5 6 _____	Fear of being alone 1 2 3 4 5 6 _____
HEALTH	1 2 3 4 5 6 _____	Distancing others 1 2 3 4 5 6 _____
Bowel Troubles	1 2 3 4 5 6 _____	SEXUAL Problems 1 2 3 4 5 6 _____
Headaches	1 2 3 4 5 6 _____	SELF CARE 1 2 3 4 5 6 _____
Stomach Trouble	1 2 3 4 5 6 _____	School Behavior 1 2 3 4 5 6 _____
Binging/Purging	1 2 3 4 5 6 _____	Grades 1 2 3 4 5 6 _____
THOUGHTS	1 2 3 4 5 6 _____	Legal Matter 1 2 3 4 5 6 _____
Making Decisions	1 2 3 4 5 6 _____	Stress 1 2 3 4 5 6 _____
Memory	1 2 3 4 5 6 _____	Incest 1 2 3 4 5 6 _____
Confusion	1 2 3 4 5 6 _____	

LIST ANY OTHER CONCERNS YOU MAY HAVE \_\_\_\_\_

\_\_\_\_\_

## OPTIONAL QUESTIONS

Rate your child's level of activity on a scale of 1 - 10, where 1 is low and 10 is high: \_\_\_\_\_

What activities does your child engage in for fun and play? \_\_\_\_\_

\_\_\_\_\_

How much attention do you pay to your child's physical health? Please explain. \_\_\_\_\_

\_\_\_\_\_

How socially involved is your child on a scale of 1 - 10, where 1 is low and 10 is high? \_\_\_\_\_

With whom does your child have the most conflict? Over what issues? \_\_\_\_\_

\_\_\_\_\_

Who are the people that are important in your child's life? \_\_\_\_\_

\_\_\_\_\_

What losses has your child experienced in his/her life? \_\_\_\_\_

\_\_\_\_\_

How many hours each week is the television on in your home? \_\_\_\_\_

Does your child have a television in his/her bedroom? yes / no

Is television viewing monitored in your home? Please explain. \_\_\_\_\_

\_\_\_\_\_

If "everything were better" in your child's life, what would that look like? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_