The Center for Family Therapy
Training Facility of the Graduate Program in Couples and Family Therapy
University of Oregon
College of Education

POLICIES AND PROCEDURES

2012-2013
### TABLE OF CONTENTS

Assigning Clients, Rotation, and Intake ................................................................. 5-6
Billing ....................................................................................................................... 11
Blank Client File Forms .......................................................................................... 23-50
  Acknowledgement of Receipt and Thorough Review of Policy and Procedure Manual .............................................................. 53
  Authorization to Release Information .................................................................. 35-36
  Beneficial Services Agreement (Spanish version available) .................................. 41
  CFT Telephone Questionnaire ............................................................................. 23-24
  Client Questionnaire (Spanish version available) .................................................. 27-30
  Clinical Notes ........................................................................................................ 31
  Community Referral Sources ................................................................................ 43
  Contact Sheet (I and II) .......................................................................................... 45-46
  Data Entry Request ................................................................................................ 51
  Informed Consent for Treatment (Spanish version available) ............................... 25-26
  No Harm Contract .................................................................................................. 48
  Self-care Contract .................................................................................................. 47
  Service/Treatment Plan and Treatment Plan Revisions ......................................... 37-40
  Time Out Contract/No-violence Contract .............................................................. 49-50
  Transfer/Termination Form .................................................................................... 33
Client Failure to Maintain a Scheduled Appointment ........................................... 11
Client Files and Record Maintenance ..................................................................... 8-10
Client Follow-up ........................................................................................................ 12
Clinic Access (Hours of Operation, Annual Closures, Key Cards, ID Badges) ......... 5
Contact Information (Clinic, Clinical Supervisors, Clinic Administrative Staff) ....... 4
Correspondence ......................................................................................................... 12
Co-Therapy Guidelines ............................................................................................ 13
Data Collection and Research ................................................................................ 14-15
Desk Staff .................................................................................................................. 13
Dress Code ................................................................................................................ 14
  Fragrance Policy ...................................................................................................... 14
Emergency Sessions ................................................................................................ 10
Equipment .................................................................................................................. 13
Fee Information .......................................................................................................... 10-11
Guidelines for Clients Leaving from and Returning to Therapy Sessions ............ 10
Guidelines for Removing Children from Therapy Sessions .................................. 10
Guidelines for Session Notes .................................................................................. 18
Health Insurance Reimbursement ............................................................................ 11
Life Cycle of a Client File ......................................................................................... 16
List of Client File Forms ........................................................................................... 17
Minor Children in Therapy ....................................................................................... 10
Out-of-Office Client Contacts .................................................................................. 8
Parking ....................................................................................................................... 13
Procedures for Seeing clients .................................................................................. 6-8
  Cancellation, Sessions, Client Flow ..................................................................... 7-8
  Scheduling and Titanium ..................................................................................... 6-7
Professional Conduct ............................................................................................... 31-22
  Faculty-Student and Peer Relationships .............................................................. 22
  Therapist-Client Relationships .......................................................................... 21
Referral Sources ........................................................................................................ 12
Scheduling and Making Calls ................................................................................. 6-8
Special Concerns ...................................................................................................... 19-21
  Clients Exhibiting High Risk Behaviors ............................................................ 19
  Clients Involving Suspected Child Abuse ........................................................... 19-20
  Court Mandated Therapy .................................................................................... 21
  Crisis intervention ................................................................................................ 19
  Emergency Communication .................................................................................. 19
  Request for Litigation Support .......................................................................... 21
  Request for Release of Information .................................................................. 20
Staff Meetings .......................................................................................................... 14
Team Practice Guidelines ....................................................................................... 12-13
Termination of Clients ............................................................................................ 12
Therapist Message Boxes ....................................................................................... 5
Transfer of Clients .................................................................................................... 11-12
Vacations and Semester Breaks ............................................................................. 14
Visitors / Clinic Tours ............................................................................................. 14
Welcome to the Center for Family Therapy ............................................................ 3
Welcome to the Center for Family Therapy!

The Center for Family Therapy is a member of the HEDCO Clinic, a multidisciplinary training clinic of the College of Education at the University of Oregon. The Center for Family Therapy is the training clinic for the Couples and Family Therapy (CFT) program. The CFT program is nationally accredited by the Commission on Accreditation for Couples and Family Therapy Education. Across their program of students, students take 90 graduate credits, two comprehensive exams and at least 400 client contact hours with at least a 5:1 client contact to supervision ratio.

The clinic provides affordable, high quality services using innovative team-based practices. Students are trained to work from a systemic and ecological theoretical framework and incorporate specific research outcomes, common factors, client motivational readiness and a strengths-based orientation in their practice.

The Center for Family Therapy works with a wide-variety of client presenting issues. Clients who need and will likely benefit from crisis services, hospitalization or other inpatient care and medication management may be referred accordingly. Clinic interns are supervised by CFT program faculty, AAMFT-Approved supervisors and Supervision Instructors. In 2012, the clinic provided more than 4,000 client contact hours to citizens in the greater Eugene-Springfield area.

Three primary projects underway at the clinic that will continue into the 2012-13 academic year include:

4. A marketing campaign to increase Center for Family Therapy name and product recognition specifically focusing on couple and family therapy and diverse populations.
5. An increase in the utilization of standardized assessments to measure clinical effectiveness at the clinic.

In addition, individual faculty and student research projects continue on an ongoing basis.

This handbook is designed to familiarize you with the policies and protocols at the CFT and the HEDCO clinic. Please review it carefully, sign the “Acknowledgement of Receipt” (last page of manual), and return that signed form to the HEDCO Clinic Manager. We will discuss your questions in Advanced Practicum and throughout the coming year in monthly clinic meetings.

The CFT faculty and staff are excited to work with you. Welcome!
CONTACT INFORMATION:

HEDCO Clinic
Center for Family Therapy
Physical Address: 170 HEDCO Building (1655 Alder Street, Suite 170)
Mailing Address: 5207 University of Oregon
Eugene, OR 97403-5207
Telephone: (541) 346-0923
Fax: (541) 346-6772

Clinical Supervisors:

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiffany Brown, Ph.D., LMFT</td>
<td>Clinical Director</td>
<td>Office: 541-346-2117</td>
</tr>
<tr>
<td></td>
<td>Clinical Supervisor</td>
<td>Cell: 541-521-0178</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 541-346-6778</td>
</tr>
<tr>
<td>Jeff Todahl, Ph.D., LMFT (KY)</td>
<td>Clinical Supervisor</td>
<td>Office: 541-346-0919</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home: 541-654-5649</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cell: 541-520-0419</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 541-346-6778</td>
</tr>
<tr>
<td>Deanna Linville, Ph.D., LMFT</td>
<td>Program Director</td>
<td>Office: 541-346-0921</td>
</tr>
<tr>
<td></td>
<td>Clinical Supervisor</td>
<td>Home: 541-485-6952</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cell: 541-913-9103</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 541-346-6778</td>
</tr>
<tr>
<td>Marlin Schultz, Ph.D., LMFT</td>
<td>Clinical Supervisor</td>
<td>Office: 541-343-9190</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Home: 541-485-6952</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cell: 541-968-5902</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 541-343-3975</td>
</tr>
</tbody>
</table>

HEDCO Clinic Administrative Staff:

<table>
<thead>
<tr>
<th>NAME</th>
<th>POSITION</th>
<th>CONTACT INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lalla Pudewell</td>
<td>Clinic Manager</td>
<td>Office: 541-346-0922</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 541-346-6772</td>
</tr>
<tr>
<td>Lindsay Elliott</td>
<td>Practicum and Contracts</td>
<td>Office: 541-346-0915</td>
</tr>
<tr>
<td></td>
<td>Coordinator</td>
<td>Fax: 541-346-6772</td>
</tr>
</tbody>
</table>
Access

- **Hours of Operation**
  The clinic is open for services Monday through Thursday, 9:00 a.m. to 8:00 p.m. (doors will open at 8:30 a.m. and close after the last session) and Friday from 9:00am to 7:00pm. No clinical services may be conducted outside of these hours, including on weekends. The clinic is not available to clinical interns to see clients afterhours, on weekends, or during holiday or break closures.

- **Holidays and Clinic Closures**
  The clinic will be closed for all University holidays (New Year’s Day, Martin Luther King, Jr. Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and day after Thanksgiving, Christmas Eve, and Christmas)
  The clinic will be closed between terms on the following schedule (2012-13):
  - Spring/Summer interim – one week closure
  - Summer/Fall interim – one week closure
  - Winter Break – two week closure
  - Spring Break – one week closure

- **Key Cards / Code Locks**
  The clinic is equipped with key card access on entry doors and interior entrances to sensitive areas.
  Clinic staff will have privileges added to UO ID cards which will enable access to locked clinic entrances. ID cards must be kept at all times for entrance into locked areas. The records room door is on a separate code lock system.

- **ID Badges**
  For the purposes of identifying clinic staff from clients or other visitors, all clinic staff will be required to wear an ID badge while working in the clinic at all times. ID badges will be provided by the clinic. Interns will be charged a fee of $10 for complete replacement badges (clip and badge). ID badges must be returned prior to completion of program or termination of employment. Temporary ID badges will be issued to authorized clinic visitors (undergraduate interns, service personnel, etc.) so they may be easily identifiable to other clinic staff.

- **Weekend Use of Clinic**
  - Therapists may use the clinic on the weekends for completing paperwork, working on client/clinic related projects, and/or watching client videos. Non-clinic related work must be done outside of the clinic.
  - Weekend use is for interns only. No clients, guests, or family members may be in the clinic.
  - Therapists will be responsible for locking the file cabinets once they have re-returned their client files.
  - Weekend use is not for returning client phone calls, as there is not a faculty supervisor on call during this time.

**Therapist Message Boxes**
All interns will have a message box located in the clinic records room (175). The box is used for messages and mail. A separate folder is housed with the intern’s client files for the purpose of receiving and storing new client assignments. Interns must check their messages at least once a day.

**Message Procedures**
- New messages will be placed in the mail box for each intern and an email will be sent as notification.
- Interns may check messages in person or ask the desk staff to relay messages if time and confidentiality allow (i.e., no clients in lobby).
- The desk staff will call interns for same-day appointment cancellations and emergency messages only.

**Assigning Clients, Rotation, and Intake**
Clients are assigned to interns on a rotational basis as inquiries are received. An Intern-Client Assignment Card Catalog is maintained at the front desk. After an intern has been assigned a client, the intern’s assignment card will then be placed at the back of the assignment order with the sequence repeating. Typically, clients will be assigned to the next available therapist within 24 hours of the initial call. New clients should be contacted by the assigned therapist to schedule an appointment within 48 hours of the initial call.
Client Assignment Procedures

• After a client contacts the clinic and completes a telephone questionnaire the client will be assigned to the next available therapist in rotation. Exceptions: a client requests a therapist by name or has a history of trauma and requests a therapist by gender.
• Interns are assigned clients in order of rotation. After a client has been assigned, the client code is written on the appropriate card and it is placed in the back of rotation. Therapists are informed they have new intakes, by email and telephone, if possible.
• High-risk intakes are reviewed by the Clinic Director prior to assignment to determine if a client is appropriate for the clinic.

Rotation Procedures

• Each therapist will have two rotation cards – one for individual clients and one for relational clients.
• Therapists may choose to remove themselves from rotation by placing their cards into the “No Clients” section. Upon accepting clients again, the cards should be placed into the back of rotation. Interns may also be taken out of rotation by direct request of the individual supervisor for the intern or by the Clinic Director.
• Therapists may not be selective about the clients assigned to them. Students are not allowed to give an intake to another clinician without speaking directly to a supervisor first. A therapist may be either in rotation and accepting any clients assigned, or out of rotation. The Clinic Director may decide to alter the rotation system to meet the clientload needs of the clinic as a whole. This may include a “relational-only” rotation where the clinic accepts only couple and family intakes.
• If on vacation, therapists should place a note stating “Vacation” and the expected date of return on their card. This will notify desk staff that the intern is temporarily not accepting clients during that time. If the card comes up in rotation during the absence, the card will remain at the front of the rotation and the intern will be assigned the first client upon return.
• If a therapist receives a “non-viable” intake then the therapist may return to the front of rotation and receive a new intake. A non-viable intake is defined as, 1) the therapist never speaks to the client due to a disconnected or incorrect telephone number, 2) the client never returns therapist’s calls, or 3) the client decides not to schedule a first appointment. Therapists should make three attempts at contact the client within two weeks of receiving intake. Non-viable intakes should be placed in the “inactive intakes” folder in the admin drawer.

Intake Procedures

• Telephone Questionnaire: After completion, the Telephone Questionnaire form will be placed in the intern’s intake folder. The intake form should remain in the intern’s intake folder until the first session is complete and the client file is created.
• Intake Session: The intern should instruct clients to arrive 30 minutes early to their first session in order to complete paperwork. The desk staff will administer all paperwork and will provide it to the intern in a yellow folder when complete. This folder will also include blank Informed Consent and Beneficial Services forms, which need to be reviewed in session.
• After Intake Session: The intern should return the yellow folder and its contents to the desk staff for data entry. If the desk staff is not available, the yellow folder can be placed in the Data Entry folder the Terminated Files and Data Entry drawer in the CFT file cabinet in the records room. The paperwork will be returned to the intern after data entry has been completed.

Scheduling and Making Calls

All therapy sessions at the clinic are by prior appointment. Appointments may be scheduled during authorized clinic operational hours and in designated CFT treatment rooms only. Therapists should use designated clinic telephones to place calls to clients. Use of cell phones or calls made from non-secure locations is prohibited. All appointments must be recorded immediately in the clinic scheduling system.

Procedures for Seeing Clients

Scheduling
• The clinic utilizes an electronic scheduling system, Titanium. Interns will receive an orientation and training on this system.
• Interns are responsible for scheduling and canceling their own appointments. If sick, interns may obtain client phone numbers from the desk staff on duty; however, interns must make all cancellation/rescheduling calls personally unless physically incapable of doing so. Interns should contact their supervisor in such cases.
• The scheduling system is shared by all clinicians at the HEDCO clinic. Interns are not authorized to alter or move appointments that are not their own.
• The CFT program is allotted a specific number of treatment rooms each term, marked with a light green placeholder. Interns are not allowed to schedule appointments in treatment rooms designated for another clinic.
• If there are no CFT rooms available, you may ask clinic management if another room is available.
• Appointments may be scheduled no more than four weeks in advance.

Titanium Checklist
• CFT interns must enter appointments into Titanium promptly. Include the following information:
  o Client code
  o Therapist – add yourself to the Scheduling tab
  o Relational sessions will need all clients added – Client tab.
  o Note any fee changes in Titanium
    ▪ If fee is discounted, include the start and stop date of the discount.

Confirming Appointment Times
• The desk staff is authorized to confirm with clients same-day appointments only. Clients will be asked to confirm personal information to confirm they are a member of the client before appointment information will be released over the telephone.

Client Cancelled Sessions
• Interns will be called by the desk staff if a client cancels the same day of the appointment time. Calls are not routinely made for cancellations with longer notice.
• When a client cancels through the front desk, the desk staff will indicate the cancellation in the scheduling system. If the client communicates the cancellation directly to the intern, then it is the intern’s responsibility to update the scheduling system.

Therapist Cancelled Sessions
• Therapists may cancel appointments due to emergency, sickness, etc.
• Therapists will contact their supervisor or clinic director and provide the following information.
  o Dates of absence and expected date of return
  o Clarify if client appointments been cancelled or if they need to be.
  o Has the cancellation been noted in Titanium and clinic management/desk staff have been notified.
  o If a client asks why the appointment was cancelled, what may we share with them?
  o Can we contact you by phone or email?

Session Times
• Sessions begin on the hour and run 50 minutes in length. If a longer session is needed, supervisor approval must be obtained prior to scheduling. The Clinic Manager should be informed when permission for longer sessions has been granted.
• The CFT appointments do not operate on a staggered schedule as some physician’s offices do. If a session starts late, it should still end on time. If one session runs long, subsequent sessions will be cut short to return to the schedule.
• No session should continue past 7:50 pm. The clinic closes at 8:00 pm Monday through Thursday and at 7:00pm on Friday.

Client Flow
• Ten minutes prior to the hour of the appointment, therapists may check the room, adjusting furniture and blinds as needed, and setting up the recording system.
• Once clients are indicated as present via Titanium, therapists are to greet clients in the waiting room and bring back to the therapy room.
• At the end of the session, therapists are to walk their clients to the scheduling counter near the back exit. At this time, confirm the next scheduled appointment before the client exits the building.
• If you moved any chairs out of the room or brought in any additional chairs or materials, please return them to where they belong.

Late Session Procedure
• When room you are scheduled for has a session running overtime that is from the same program (CFT), you may knock on the door. When the late session is run by a different program (CDS, Reading), therapists
need to report the issue to clinic management. The management team will knock on the door for you and in some circumstances may assign you to another room.

- On rare occasions, you may have a session that runs over due to an urgent situation. If you receive a knock on your room door, please come to the door and let the clinic staff/therapist know of your situation so that they may plan accordingly.

**Post-session**

- Interns are responsible for leaving the therapy rooms in a clean and orderly state, including attending to spills and play-therapy messes. If repairs are needed, interns should inform the Clinic Manager so they can be addressed.
- All supplies should be returned to the appropriate storage after sessions are complete.
- All artwork created during session must be removed from the therapy room (to be filed or shredded), and any notes written on the white boards should be erased.
- Each room is supplied with a small whiteboard. White boards may be removed from session rooms if there is not time to copy down the information posted (e.g., genograms) before the next session. They should be returned as soon as possible so other interns may use them during their sessions. Larger whiteboards are available in the CFT storage in 180D and must be returned to this location after use.

**Call Making Procedures**

**Local Calls**

- For general calls and for clients that accept blocked calls –
  - Pick up receiver
  - Dial #71 to block the telephone number (prevents number from being released on caller ID)
  - Dial 9 to get an outside line
  - Dial area code and telephone number

- For clients who do not accept blocked calls –
  - Wait until the “6-0923” button on the right hand side of the telephone is available (i.e., no green lights lit). This button gives the appearance that the call is being placed from the front desk phone. Only the main clinic telephone number will appear on caller ID.
  - Pick up receiver and press the “6-0923” button.
  - Dial 9 to get an outside line.
  - Dial area code and telephone number

**Long Distance Calls**

- Use the option for blocked or unblocked calls listed above that is appropriate for the call.
- Dial 9 to get an outside line.
- Dial 1 + area code and telephone number
- After beep enter long distance code program for CFT (5265316)
- The clinic is charged for all long distance calls. Interns should use a calling card when making personal calls.
- The long distance code is also needed when faxing long-distance (code is posted on fax machine).

**Using Front Office Phones**

- Client calls made from the front desk area should be avoided due to confidentiality concerns.
- If a client calls the main line while an intern is in the clinic, the desk staff can transfer the call back to the student/observation room phone.

**Out-of Office Client Contacts**

As a general rule, all contacts between the intern and client are restricted to scheduled times in the CFT. Exceptions to this rule (such as informal out-of-office meetings, at home visits, hospital visits, etc.) require prior supervisory permission.

**Client Files and Record Maintenance**

Interns are responsible for maintaining up-to-date clinical records and demographic information on each client in their care. Appropriate CFT forms should be completed promptly and a copy put in the client’s file. It is the responsibility of the intern to safeguard active client files and to insure the confidentiality of all client records until a client is closed.
Client records (originals and copies) stay in the CFT at all times, with the following exceptions:

- As specifically authorized by a signed release from the client(s) (requires the signature of all individuals 18 years of age or older who attended the sessions). This should be reviewed and co-signed by the supervisor prior to release.
- As part of supervision. All students are required to transport all client material to and from supervision in a locked briefcase or bag – this includes client lists, client progress notes, written assignments based on client material, and all video and audio tapes.

Clinicians will adhere to the following protocols when preparing, handling, and storing client records (records include client files, video recordings, correspondence, supervision notes, and any other information pertaining to a client):

- Clinical records should never be left unattended by the intern. Records should be immediately re-filed after each review.
- All confidential client documentation must be completed on the clinic premises. Interns may not save client notes, treatment plans, or other confidential information on any clinic computer or personal laptop hard drive. Interns may temporarily save documents-in-progress to an encrypted flash drive, which must be stored in the clinic at all times and may not be used for other purposes outside the clinic (information on encryption can be obtained from the clinic manager). These documents must be deleted from the encrypted flash drive as soon as they are completed and printed.
- Digital recordings of clients must remain on the secure video network and may not be transported from the clinic, even in encrypted format, unless expressly permitted by a supervisor. Supervisors have access to the video server from their offices, so transportation of video should be a rare occurrence.
- Terminated clients should be promptly closed and appropriately filed.
- Supervisors and the Clinical Director maintain full access to a supervisee’s clinical records at all times.
- All client folders are to be coded to ensure client confidentiality. Client codes (not names) should be used: to identify client files (on file tab); in the master schedule; in intern appointment books; or on any document where client confidentiality is a concern. The client code (assigned at intake) will be comprised of the first two letters of the client’s last name, plus the first two letters of the client’s first name, plus either the letters W (for winter), SP (for spring), SU (for summer) or F (for fall) plus the year services began. Example: If the client name is Jane Doe, and she was seen in the Fall of 2011, the client code would be: DOJA F11.

The clinical director serves as custodian of all terminated or inactive client records. Upon execution of appropriate written releases of information, requests for records by third parties should be made through the clinical director.

Changes in client status and treatment objectives may result in a new client file being created. The following guidelines should be used in consultation with your supervisor to determine if a new client file (and database client record) should be created:

1. If a member of a couple or family client wishes to work on individual goals, then a new file should be created and kept separately from the original.
2. If a couple or family unit changes during therapy due to a break-up, separation, divorce or other major change that results in the exclusion of an adult client member, a new file should be made. A copy of the client questionnaire and a new informed consent (if multiple clients signed original) should be placed in the new file.
3. If a member of a couple client wishes to have individual therapy that still focuses on the couple’s goals, the records for those sessions can remain in the couple’s file. This also applies to a member of a family client seeking individual therapy that focuses on family goals.

A file may be reopened if it was terminated within the past six months if the clients, client status (individual, couple, family), and presenting problem have not changed. If any of these items have changed, then a new client file (and database client record) should be created. A new informed consent form should be signed by the client.

**Client File Procedures**

- **File Creation:** Interns are responsible for making their own client files after the intake session has been completed and paperwork has been returned after data entry. File-making materials (folders, hole-punch, and fasteners) are located in the student/observation room storage cabinet. Sample files showing the order of file contents are available in the student room.

- **File Labels:** Using a label maker, interns should create a label to be affixed to the folder tab. The file label consists of the four-letter client code (as assigned at intake), the term initials (F, SP, W or SU) and the year services began. The client code is based on the initials (first two of last name, first two of first
name) of the client who completed the telephone intake. This code should not be changed without consultation with the Clinic Manager to ensure database accuracy.

**Emergency Sessions**
Should an emergency situation requiring immediate response arise, the intern should consult with their assigned supervisor. (If the intern is unable to reach their supervisor, they should contact the assigned supervisor on call, the clinical director or the program director in that order). The client may be seen at the CFT or referral may be made to the appropriate community resource.

**Minor Children in Therapy**
Clients who are minors, but are 14 years of age or older, have the legal right to initiate and assent to therapy. In these rare clients, it is expected that therapists will immediately consult with their supervisor regarding appropriate contact with the minors’ parent(s) or legal guardian(s).

When custody of a minor child may be in question due to separation, divorce, or unmarried parent, proof of legal custody is required prior to treatment. Proof may be demonstrated through a divorce decree, custody agreement, separation agreement, or other proof of legal guardianship. A copy of records should be included in the client file. Parental consent forms are available in the student/observation room and front office for obtaining consent for services from the custodial parent.

**Guidelines for Removing Children from Therapy Sessions**
Therapists should avoid a situation in which children are removed from a therapy session and placed in the clinic waiting room. Alternatives include scheduling a co-therapist for sessions with families or scheduling separate sessions for parents and children. Per HEDCO Clinic policy, no children under the age of twelve should be left in the waiting room at any time without adult supervision (clinic administrative or front desk staff cannot provide supervision). If adequate adult supervision cannot be found, the children should remain in session or the session should be rescheduled for a time when the children are not present.

**Guidelines for Clients Leaving from or Returning to Therapy Sessions**
Therapists may need to excuse a client from a therapy session for a variety of reasons (e.g., restroom breaks, to allow individual work during a couple or family session, or safety issues with regards to domestic violence). In circumstances where a client must leave a session, please adhere to the following protocol:
1. Therapist will escort the client to the waiting room and provide the desk staff on duty instructions as needed.
2. Therapist will escort the client back to the session room, or, if prior permission to return to session has been granted by the therapist, the desk staff will escort the client back to the session room.
3. No staff will allow a client to return to a session room without prior verbal instruction from the therapist. If a client approaches the desk staff requesting a return to session and no prior consent has been given by the therapist, the desk staff will interrupt session to obtain permission.
4. If a client leaves voluntarily or is excluded from a session due to safety concerns, the therapist will inform the desk staff on duty of the situation so they can be prepared for unusual behavior in the waiting room.

**Fees**
Our services are offered on a sliding scale fee basis, payable at the end of each session. Fees range from $15 to $100, based on a client’s household income. A $15 assessment fee is charged for the first appointment. In client of cancellation, 24-hour notice should be given to avoid a charge for the session (cancellation charge is at therapist’s discretion).

<table>
<thead>
<tr>
<th>Annual Household Income</th>
<th>Fee</th>
<th>Annual Household Income</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below $15,000</td>
<td>$15</td>
<td>$55,001 - $60,000</td>
<td>$60</td>
</tr>
<tr>
<td>$15,001 - $20,000</td>
<td>$20</td>
<td>$60,001 - $65,000</td>
<td>$65</td>
</tr>
<tr>
<td>$20,001 - $25,000</td>
<td>$25</td>
<td>$65,001 - $70,000</td>
<td>$70</td>
</tr>
<tr>
<td>$25,001 - $30,000</td>
<td>$30</td>
<td>$70,001 - $75,000</td>
<td>$75</td>
</tr>
<tr>
<td>$30,001 - $35,000</td>
<td>$35</td>
<td>$75,001 - $80,000</td>
<td>$80</td>
</tr>
<tr>
<td>$35,001 - $40,000</td>
<td>$40</td>
<td>$80,001 - $85,000</td>
<td>$85</td>
</tr>
<tr>
<td>$40,001 - $45,000</td>
<td>$45</td>
<td>$85,001 - $90,000</td>
<td>$90</td>
</tr>
<tr>
<td>$45,001 - $50,000</td>
<td>$50</td>
<td>$90,001 - $95,000</td>
<td>$95</td>
</tr>
<tr>
<td>$50,001 - $55,000</td>
<td>$55</td>
<td>$95,001 - $100,000</td>
<td>$100</td>
</tr>
</tbody>
</table>
Payment of Fees
Fees are payable at the time of each visit. Clients should be informed at the time of the initial telephone contact that there is a fee for services performed at the clinic and that arrangements should be made by the client for full payment of fees at the time of each appointment.

Payment Procedures

- **Fees:** Interns determine client fee based on sliding fee scale or negotiated rate
- **Reporting the Assessed Fee:** Interns report the assessed fee on the Informed Consent form. Desk staff will enter the fee information into the scheduling and billing system. Any changes in fees should be reported to the desk staff on duty so the information can be updated in the scheduling and billing system.
- **Payments:**
  - The desk staff will process payment from the client before each session, charging the fee currently on file in the scheduling and billing system. If a client fails to pay for a session, the desk staff will inform the intern by providing them a payment notification slip. It is the intern’s responsibility to track payments in the client file.
  - Clients may skip a payment as long as the intern makes record of this in the file and arranges future payment.
  - The clinic does not accept pre-payment for services.

Billing
While it is the policy of the center that arrangements be made for full payment for services rendered at the time of each visit, the clinic does have a mechanism for billing clients or a third party if necessary. Billing statements will be printed once per month. Your client’s statements will be placed in your mailbox and you will be responsible for giving them to the client and discussing any payment/fee arrangements.

Free Therapy
The clinic does not provide free therapy. Such arrangements tend to undervalue the therapeutic process. This can have an adverse effect on the commitment and motivation of some clients toward the therapeutic process, thus prolonging therapy unnecessarily. As such, payment of an appropriate fee for professional services is an important consideration. In clients of financial necessity, fee adjustments may be offered. These adjustments carry specific conditions, which must be maintained by the client. Before offering a reduced rate to a client, interns should have a detailed discussion with their supervisor. The supervisor must approve the reduced rate. The desk staff must be informed of the reduced rate so the client will be charged the correct fee. See eligibility for payment reduction outlined below.

Eligibility for Payment Reduction
Payment reduction is available, on a very exceptional basis, when essential. Approval for fee reduction requires a conversation with the intern’s individual supervisor and, once approved, written documentation in the client file. No form is used for this arrangement – though a record that details the date, the change in fee, and a review date is added on the right side of the file with the clinical notes. Fee reductions are temporary and shall not exceed three sessions. Beyond three sessions, an additional conversation with the individual supervisor is required. The desk staff must be informed of any changes in fees, so the correct fee is charged to the client.

Health Insurance Reimbursement
Insurance policies vary widely regarding reimbursement for mental health services. Any question of coverage is a matter between the policyholder and insurance company. Clients may wish to contact their insurance company to inquire about the extent of policy coverage for services provided at the clinic. Upon execution of a signed release of information, the clinic can provide a standard receipt, which is generally acceptable for submission for insurance reimbursement.

Client Failure to Maintain a Scheduled Appointment
If the client fails to show for a session, it is the therapist’s responsibility to clarify with the client whether they are planning to return for treatment. If the client states that they do not wish to continue in therapy at this time, the file is closed and proper termination paperwork documented in the file. If a client routinely misses appointments, directly address this issue in session and with your supervisor. In these situations, it is customary to send a letter to your client. A standard letter is available on the clinic computer in the observation room. If the client does not respond to your letter, promptly close the file.

Transfer of Clients
The CFT clinic follows campus policies for diversity and equal opportunity in its method of assigning clients. On occasion, clients may request a transfer to a new therapist. Sometimes these requests are due to valid concerns
(e.g., client has requested a therapist of a specific gender due to a history of trauma) and other times it may be a personal preference. If a client requests a transfer to a new therapist, interns should adhere to the following protocol:

1. Therapist will contact their individual supervisor to discuss the request.
2. Depending on the circumstances, the therapist will be advised to offer the client one or more options for continuing with services:
   a. Continuing with the current therapist
   b. Continuing with the current therapist and adding a co-therapist
   c. Transferring to a new therapist within the CFT
   d. Referring the client to an outside agency (therapist needs to provide 3 referrals at this time)
3. The therapist will inform the desk staff on duty if the client will be transferred to a new therapist so it can be reassigned in the database.
4. If the client contacts the clinic with a request for a new therapist (versus talking with the therapist directly), the following steps will be taken:
   a. The clinic manager will simultaneously notify the therapist and their current supervisor.
   b. The current supervisor and therapist will discuss the request, and the therapist will be advised to follow the above protocol.

Termination of Clients
Following efforts to address the issues in active collaboration with a supervisor, a client may be terminated when any of the following occur:
1. The goals of therapy have been accomplished and the therapist and client agree to terminate treatment.
2. The client(s) fail to follow prescribed treatment directives that have been discussed fully and agreed upon during therapy sessions.
3. The client(s) fail to seek additional support services deemed as necessary by the clinician in full discussion with the client.
4. The client(s) engage the services of another therapist while currently in treatment at the Center for Family Therapy and this is deemed by the therapist/supervisor to provide a plausible probability of iatrogenic effects (i.e. work to the client’s disadvantage).
5. The client(s) consistently fail to make payment for services when they are rendered. Immediately upon termination, all necessary forms must be completed and placed in the folder. The terminated file should be reviewed by the supervisor, co-signed, and properly placed in the termination file at the clinic.

Client Follow-Up
Each therapist is encouraged to conduct a follow-up telephone call with terminated clients at one month, three months and six months after the date of termination. Each call should be noted on the Client Contact Sheet in the client file.

Referral Sources
When receiving a referral from a community source such as a minister, teacher, physician, etc. it is appropriate to acknowledge (by telephone or correspondence) that the referral has been seen as long as the client agrees to this contact. The client(s) will need to complete a release of information for the therapist to acknowledge the referral. Specific information concerning the client (including but not limited to name, presenting concern, or details of the client) should not be provided to the referral source without first obtaining specific written permission from the client.

Correspondence
With Clients
Telephone contacts with clients should be noted on the Client Contact Sheet indicating the date and nature of the telephone contact. A copy of all correspondence sent to a client should be placed in the client file and recorded on the client contact sheet. Additionally, a copy of all correspondence received from a client, including notes, cards, etc. should be placed in the client’s file.

With Other Sources
All requests for client information (such as a copy of the client’s file) should be brought to the attention of the intern’s supervisor and the clinical director. Requests for information concerning clients can only be provided to outside sources after securing a written release from all adults who participated in the therapy sessions.

Team Practice Guidelines
1. Team therapists (behind the mirror) must be involved in more than 80% of the total client contact hours and must take an active part in the therapy process to have the hours count as client contact.
2. Therapists should consult with team members each session. This includes for each session conducting a pre-
   session meeting, consultation during a break in the session, and post session follow-up.
3. There should be no more than three team members behind the mirror for each client.
4. If a team member agrees to be on a team, they must commit to be on the team for the entirety of the client
   from the point of joining the team.
5. The therapist of record for the client directs and maintains ultimate decision making authority in the client
   (with supervisory oversight).

Co-therapy Guidelines
1. While co-therapy offers advantages to student practitioners with regard to breadth of clinical experience and
   exposure, therapists practicing co-therapy are expected to be familiar with the disadvantages of co-therapy
   and make every effort to minimize these disadvantages (see attached document). Therapist should make
   every effort to resolve differences and conflicts as they arise, and consult with their supervisor when
   necessary.
2. The therapist of record must take responsibility for the client, decide and direct the overall direction of therapy,
   and be responsible for all client documentation and follow-up.
3. Should a difference in opinion occur with regard to the therapy process, the therapist of record maintains final
   decision making authority (with supervisory oversight).
4. The therapist of record seeks supervision for the client system.

Equipment
Interns should familiarize themselves with the operation of video equipment at the clinic. Interns should inform the
Clinic Manager of any equipment malfunction or issues of poor picture or sound. When reporting issues, identify
the exact equipment (computer, printer, camera, etc.), issue, room, date and time that the occurrence took place.

Equipment Procedures

Session Video Recording
- Interns will receive an orientation and training on session observation and recording equipment and
  procedures.
- Recording will be started and stopped from in-room laptops (instructions to be provided).
- In-room laptops can also be used for playback of recorded video.
- Observation computers in the three observation rooms can be logged into the camera feed for any
  therapy room. See HEDCO Clinic observation room practices section for restrictions.
- Headphones have volume control on the console and on the cord. Volume should be turned down
  when observation is concluded to prevent wear on the headphones.
- Supervisors will have the capability to view therapy sessions and recorded video of their supervisees
  from offices within the HEDCO building.

Video Editing
- Observation computers are outfitted with video editing software for the purposes of editing clips for
  class assignments or presentations as allowed by program (instructions will be provided). See HEDCO
  Clinic recording policy for recording restrictions.

Parking
Clients may park in the patient/client parking lot #19 to the south of the HEDCO building. In order to park in this lot,
clients must obtain a parking pass from the clinic. Clients will be responsible for paying for their parking, if
applicable and for any tickets earned while parking.
The clinic does not provide parking to clinic interns. As students, interns are eligible to purchase UO parking passes
for the purpose of parking in designated campus lots. Interns should contact the Office of Public Safety for more
information on parking passes, rules, and enforcement. Interns are not allowed to park in client parking lots.

Desk Staff
The desk staff consists of student employees hired for reception and scheduling duties, and to assist the Clinic
Manager in the daily operations of the clinic. CFT interns are asked to not assign tasks or make requests of the desk
staff’s time that are beyond the scope of their duties. Desk staff should not be asked to call clients on an intern’s
behalf for any reason, facilitate scheduling with a client, or conduct any other personal requests. Questions or
concerns about desk staff duties or performance should be directed to the Clinic Manager.
Visitors / Clinic Tours
For confidentiality reasons, interns are to refrain from having guests/family in the clinic (including the waiting room). Typically, the clinic will open for family tours on or near graduation day. Tours are not allowed at any other time.

Dress Code
Interns should maintain professional appearance at all times when working in the clinic. Professional appearance shows respect for clients, the facility, and the programs being represented.
Dress should not include:
- logo t-shirts, workout clothing (e.g., sweat shirts, sweatpants, or track clothing)
- clothing that is excessively tight or short, exposes undergarments, mid-drifts, or excessive cleavage
- garments or shoes that are stained, dirty, or in disrepair
- garments or shoes that restrict movement necessary to complete service or work functions, or are a distraction to the workplace
- scented body products
The HEDCO Clinic has a low/no fragrance policy. Strong scents or heavy concentrations of body scenting products which others may find personally offensive or cause discomforting symptoms are not appropriate in the clinic setting.

Social Networking
Interns are not allowed, for any reason, to mention clients, therapy, or seeing clients in any way on social networking sites such as Facebook and Twitter. This is a breach of confidentiality, even if you are “vague” in your statements or provide positive sentiments. Please consider your professionalism on social networking sites and change your settings to private to avoid client systems finding you on these kinds of site.

Vacations and Term Breaks
- Interns should make specific arrangements with their clients for appropriate continuity of care during periods that the intern will be unavailable. During periods of absence, the therapist under supervisory direction should provide the client with the name and telephone number of professional support in the event of an emergency situation, consistent with the nature of the client’s needs. Please note the schedule for clinic closures outlined in the “Access” section of this handbook when planning vacations.
- Interns on break will write a note with the dates of their absence and attach it to their rotation card. If their card is in the front of the box, but they will not be in the clinic for two or more days, their card will be skipped and the intake will be given to the next available intern.

Staff Meetings
CFT clinic staff meetings typically take place the first Thursday of each month. These meetings are mandatory and require Clinic Director approval for absences.

Data Collection and Research
The CFT maintains a client database containing data obtained from client questionnaires and surveys that are administered throughout treatment.

OQ-45 Questionnaire
At intake, 3rd, 5th, 10th and every subsequent 10th session, clients will be asked to complete a questionnaire using a handheld computer (PDA). The OQ-45 monitors the client’s experiences and emotional state over the past week and can show change over time. The report will also indicate any extreme responses to questions (e.g., if client has had suicidal thoughts). Interns are required to participate in this data gathering process; however, clients may choose to opt out (consultation with supervisor should be made in such clients).

OQ-45 Procedures
- When scheduling a session for which a questionnaire will be administered, interns should select the appointment type listed as “OQ-45/PDA Needed”. This designation will make the appointment marker appear bright green, indicating to the desk staff that a questionnaire is needed.
- The desk staff will administer the OQ-45 questionnaire on scheduled sessions before the start of session. A report will be brought to the intern prior to the start of session. Intern will be informed of technical issues that may result in a report being unavailable.
- The questionnaire typically takes less than five minutes; however, early arrival of clients is encouraged to ensure that session time is minimally affected.
- If a scheduled questionnaire is missed, intern may request that one be administered by changing the appointment type in the scheduling computer to indicate an OQ-45 is needed (appointment will appear in bright green on scheduler).
- Interns should document the administration of the OQ-45 in the client contact log.

**Database**

The CFT maintains a database of client information obtained from intake questionnaires and periodic research and client satisfaction surveys. The database generates data used in annual clinic reports and research, so its accuracy is essential.

**Database Procedures**

- To keep data current, a Data Entry Request form (available in the front office at the clinic) should be completed any time the following occurs:
  - Change in client-type (individual, couple, or family), including the creation of a new client file or division of client files into new components (e.g., couple will be seen as individuals)
  - Addition of a client to a client
  - Change in client contact information
  - Client is transferred to a new intern
  - A co-therapist is added to the client
- The Data Entry Request form should be placed in the Data Entry folder in the Admin drawer. Desk staff will pull the file, make changes to the database, then return the file and form to intern’s file drawer.
Life Cycle of a Client File

Client calls or drops in to clinic.

- Telephone Questionnaire is completed.
- Desk staff enters data into CFT database, assigns client and designates its status as “Intake”.
- Telephone Questionnaire given to Intern.

Intake Scheduled

- Client completes Client Questionnaire and other data surveys.
- Desk staff provides client paperwork to intern before session.
- Session is completed.

No Intake Scheduled

- Intern signs off on Telephone Questionnaire as “Inactive” and places it in Inactive Intakes file in the Admin drawer.
- Desk staff records reason for inactive status in database, and designates it as “Destroyed”.
- Telephone Questionnaire is destroyed.

Therapy Sessions Occur

- Intern completes Data Entry Request form and places in Data Entry file in the Admin drawer when any change to client occurs (transfer, change in client type, etc.)
- Desk staff retrieves file, completes data update and returns file to intern’s drawer.

Client Terminates

- After supervisor has signed off on termination form, file is placed in Terminated Files drawer.
- Desk staff terminates client in database, designates client status as “CFT-Archive.”

- Physical client files are stored at the CFT for up to two years after termination.
- After two years, client files will be stored at the UO Archive Storage facility. Desk staff will designate in the database “UO-Archive” for the client status. Client file is packed in boxes with other terminated clients and delivered to archives facility.

- Physical client files are retained for fifteen years following the date of termination. The database will generate the date of file destruction for each file after termination.
- At point of file destruction, desk staff changes client file status to “File Destroyed.”
Client File Forms

Telephone Questionnaire
This form is used at the time of client’s initial call to the Center. Desk staff will provide information about Center’s services and complete form with information provided by client.

Informed Consent for Treatment/Therapeutic Contract
To be completed by the therapist in the first session. Is a contractual agreement between the client and therapist which specifies the nature and terms of treatment at the clinic. A copy of this form should be signed by the client(s) and kept on file, and a copy should be given to the client(s) to keep. Therapy does not formally begin until the treatment agreement is signed by the clients and therefore should be completed in the first session. See the Minors in Therapy section for further guidance.

Client Questionnaire
Provides client demographic and personal information as well as a brief description of client concerns. This should be filled out by the client(s) in the lobby, prior to the client’s first (intake) session.

Clinical Notes
Serves as a clinical tool to assist the therapist in working with the client, and recording the progress of therapy. A clinical note should be completed for each therapy session no later than 24 hours from the time of the session.

Authorization to Release Information
Must be signed by all clients prior to release of information by the therapist or Center for Family Therapy staff.

Transfer/Termination
This form is to be filled out by the therapist at the end of treatment at the CFT, or when the client is transferred. A copy is kept on file at the clinic. A supervisor’s signature is required.

Initial Assessment and Treatment Plan
The form is designed to provide a clear focus for the therapy and the client with regard to the problems the client has brought to therapy and the plan generated by the therapist and client to move things in a more useful direction. The process of completing the treatment plan should be the main focus of the first few sessions in therapy and should be complete by the third session. The client(s), therapist, and supervisor must sign the completed treatment plan.

Beneficial Services Agreement
This policy statement outlines the conditions for termination of treatment. All clients should sign a copy of this policy during the intake session, and a copy kept on file at the Center for Family Therapy.

Client Contact Sheets (I and II)
Provides a record of the date of each client contact and payment of fees.

Community Referral Sources
List of community resources and referral sources with phone numbers.

“No Suicide” or “No Harm” Contract
This form is to be used as a clinical tool in situations where the therapist suspects clients are suicidal, exhibit suicidal behaviors or thoughts, threaten harm to themselves, or others. Use of this form does not absolve the therapist from doing more thorough assessments for violence and self-harm when appropriate.

Self Care Contract
This form can be used as a clinical tool to outline plans for client(s) to enact self care strategies.

“Time-Out Contract/No-Violence Contract”
This form is to be used as a clinical tool in situations where the therapist(s) suspects or knows about domestic violence. This is an agreement between clients and the therapist(s) that violence will not be used to handle conflict. Instead clients will negotiate a time out procedure to follow during times of conflict and/or escalated emotional states.

Presenting Concern Codes
Presenting concern codes by category. These codes may be used by the intern to describe the type of presenting concerns the client(s) bring to the session.

AAMFT Code of Ethics (http://www.aamft.org)
All therapists and supervisors are to uphold the AAMFT Code of Ethics.
Guidelines for Session Notes in Couples and Family Therapy

Reasons for Session Notes:
- AAMFT Code of Ethics requires therapists to keep an accurate record of therapy sessions.
- Notes help maintain continuity between session.
- Serves as a legal record of the events of the session.
- Allow for general statistical record keeping for the purpose of audit and research.
- Videotapes at the CFT are not intentionally part of the clinical record and should be erased after they are used for supervision.

Overview:
- Session note must be completed within 24 hours after the session, no exceptions, as required by law.
- Notes should reflect the progress that occurred in the session toward treatment goals.
- Therapist should sign the note at the end, which also includes their credentials (e.g. Miranda Lewis, B.S.).
- Do not go back and append your note after it is completed; no white out; initial clearly any crossed out sections.
- Write every note as if your clients or the court will read them in the future.
- No blank lines between entries. If there is a blank space, draw on diagonal line through the blank space.

Qualities of a good session note:
- Concise
- Relevant
- Objective (non-judgmental presentation of the facts)
- Written in black ink
- Legible
- Dated
- Document all people present in the session.
- Consistent with the language of the treatment plan, informed by the client’s language and goals.
- Be succinct, only focusing on the most important aspects of the session.
- Be objective. Others watching your session should be able to agree with what you saw.
- Be strength-based. Write, as you would like to be written about. (Clients have the right to read what you write about them.) This does not mean that you need to lie, play Pollyanna, or obscure. Just be respectful.
- Document your client’s suicidality, homicidality, and anything you did to keep your client and significant other safe.
- Every piece of information does not need to be in your note, especially information that might embarrass your client if he or she were to read it or it were to end up in court.
- Include any assessment, diagnosis, or intervention delivered during the session.

Outline for a SOAP note:
1. Objective for the session: In one sentence, what did you plan to do?
2. S: (Subject) What are the most striking things that your client said? Often using your client’s own words is desirable (i.e. quotations of relevant client comments).
3. O: (Objective) What do you see? Use observations rather than inferences.
4. A: (Assessment) What did you conclude from your observations? Your assessment should follow from your S & O.
5. P: (Plan) When do you plan to meet next? What will you do next time? What homework, if any, did you give? This should match the session objective for your next session and should follow from A. Sign (w/ title) and date your note.
Special Concerns

Crisis Intervention
Occasionally, clients are seen at the center that exhibit behaviors requiring timely and specialized responses on the part of the intern. Legal and ethical considerations require that such responses attempt to ensure the safety and welfare of all participants involved in the therapeutic process, as well as individuals not involved in therapy who may also be affected by the actions of a client. It is important to recognize that appropriate responses to critical situations often require creativity and flexibility. Close supervisory support is particularly important in these clients. Contact your supervisor or on-call supervisor if you need support when dealing with crisis intervention situations.

Clients Exhibiting High Risk Behaviors
Any client involving behaviors (including ideations), which indicate a reasonable possibility of risk of life, physical abuse or sexual abuse should be considered high risk. Interns should immediately consult with their supervisor in such situations. Examples of high-risk behaviors include the following:
- Suicidal thoughts or actions on the part of any participant in therapy.
- Violence, or the concern of violence emerging.
- Suspected physical abuse, sexual abuse, or neglect of a child under the age of 18 years.
- Clients in which there appears to be an acute reaction to drugs or alcohol, which present a clear and immediate danger to life.
- Any exhibited behavior which is bizarre, unstable, disoriented, or volatile and which by its nature suggest a reasonable risk to the safety of the client or others.
- Evidence of diminished functionality (such as severe depressive behavior, etc.) which presents a clear and immediate risk to the health and welfare of the client or another person.

Emergency Communication during a Session
In the event that an intern is faced with a dangerous situation in session it may be necessary for the intern to seek assistance without the client knowing. If the intern is unable to leave the room safely, the following should occur:

1. Intern will call main clinic number to speak with desk staff (dial 6-0923 or press speed dial button for this extension). In the event the desk staff does not answer, the clinician should call the Clinic Manager (dial 6-0915 or press speed dial button for this extension) or call a supervisor (numbers posted on telephone in session room).
2. When the call is answered, the clinician should identify his/herself and the therapy room number, and state, “My session is running long, can you call Mr. Smith to cancel his appointment?”
3. The staff person should respond to this prompt with a series of “Yes” or “No” questions. Below are the questions in order. The clinician should respond to each question on the phone to help the staff determine the type of help that may be needed.
   - Are you in danger?
   - Do you need me to call the police?
   - Do you need me to call a supervisor?
   - Do you need someone to watch your session?
   - Do you need someone to come to stand outside the room?
   - Do you need someone to knock on the door?
4. If the clinician answers “yes” to any of the questions, the staff person will immediately take the requested action(s) upon hanging up the call (e.g., call police, call supervisor, knock on door, etc.)
5. The staff person will seek advisement from the Clinic Manager or on-call supervisor if there is any ambiguity on the course of action.
6. If the police are called (either Eugene Police or UO Department of Public Safety may be called) staff should:
   - Explain the situation as quickly as possible – Example, “I am calling from a University of Oregon clinic. A therapist, who is alone with a client, is in danger and asked that I call the police. I do not know anything more about the situation in the room.”
   - Be ready to provide the building name and street address (170 Hedco Education Building, 1655 Alder St, suite 170) and the cross streets (Alder and 17th).
   - Direct officers to the correct therapy room upon arrival.
7. All incidences of this protocol being used should be reported to the Clinic Manager so that the procedure can be evaluated with the Clinic Director.

Clients Involving Suspected Child Abuse
All clients involving reasonable suspicion of child and elder abuse require that a mandatory reporter “… shall immediately report or cause a report to be made” (ORS 419B.010). The proper contact number is listed in small print on
each phone at the CFT. Given the complexity of these situations, always contact your individual supervisor or the supervisor on call prior to making a CPS report.

**Request for Release of Information**

All requests for information by third parties shall be reviewed by a supervisor. Under no circumstances will a therapist allow information to be released to a third party without written permission from the client(s). The release should be specific and dated. A copy should be placed in the client’s file. Client requests for copies of records must be submitted in writing with a description of requested documents and a stated intent of use. A copy of this documentation should be placed in the client’s file.

The clinic does not generally release photocopies of client records but rather will issue treatment summaries or records of attendance if the appropriate written requests have been obtained. The following protocol should be followed for the release of client records. Please note that in clients where there are multiple clients (couples and families), all adult clients must sign requests and provide identification as indicated below or no information may be released. A handout summarizing this information is available to distribute to clients.

**Requests from current clients or recently terminated clients (for treatment summary or record of attendance requests only):**

- The therapist of record should process the request in consultation with a supervisor.
- The therapist must obtain a CFT Release of Information form signed by all adult clients on the client. Original signatures are required (no photocopies or fax copies). This request must include: Name, signature, Date of Birth, and Social Security Number. It must also outline the following: specific information being requested (e.g., dates of attendance, treatment summary, intake summary, etc.), and the reason for the request (e.g., proof of treatment for court hearing, custody hearing, disability hearing, etc.).
- Information should be released directly to the client(s) in person. If information is being released by a staff member designated by the therapist of record, the client(s) must present state-issued photo identification (all adult members of the client must be present). Client information may not be released via fax or mail.

**Requests from former clients (for treatment summary or record of attendance requests only):**

- The CFT Clinic Manager should process the request in consultation with the Clinic Director.
- A written request (a letter or Release of Information form may be used), signed by all adult clients on the client, must be obtained. This request must include: Name, signature, Date of Birth, and Social Security Number. It must also outline the following: specific information being requested (e.g., dates of attendance, treatment summary, intake summary, etc.), and the reason for the request (e.g., proof of treatment for court hearing, custody hearing, disability hearing, etc.).
- Information should be released directly to the client(s) in person. Client(s) must present state-issued photo identification when picking up information (all adult members of a client must be present). A photocopy of the identification will be placed in the file. Client information may not be released via fax or mail.

**Release of photocopied records:**

The CFT Clinic Director or Clinical Supervisor must evaluate requests for photocopies of original records. In the rare event that client(s) must obtain photocopies of file documents (client notes, assessments, evaluations, etc.), the following protocol should be applied:

- The client(s) should be informed by their therapist, clinic director, or supervisor of the risks of releasing complete documents to themselves or a third party (e.g., documents could be lost, information may be misinterpreted or misused).
- Client(s) should be encouraged to find out specifically how records will be used if being presented to a third party.
- Client(s) will be responsible for paying a $20 fee for photocopying records.
- Client(s) will need to present state-issued photo identification (copy should be made and placed in the original file) and sign an Acknowledgement of Receipt of the requested file contents. This document will be placed in the client file. It is the client’s responsibility to deliver information to third parties. Client information may not be released via fax or mail.

**Release of Information after the death of a client:**

In the rare circumstance that a family member wishes to obtain records of a deceased client, the following protocol should be applied:

- To request confidential records of a family member after the death of the family member, the requester would need to produce legal documents that demonstrate that they have access to those records, in keeping with the law.
- One method to produce this documentation is to become the “executor of the estate” of the deceased. If this is the client, the family member would need to provide a conformed copy of the court order appointing him or her as the “executor of the estate” of the deceased along with valid identification. A conformed copy is one that bears the court’s stamp indicating that it has been filed with the court.
Oregon allows an abbreviated procedure for handling small estates that would otherwise require a full probate. The procedure involves filing a document called an "affidavit of claiming successor." This abbreviated procedure can be used if the estate’s personal property is valued at no more than $50,000 and real property is valued at no more than $150,000, for a total aggregate estate value of no more than $200,000. The person submitting the affidavit must provide a certified copy of the filed affidavit in order to obtain the records.

Request for Litigation Support
Couples and Family Therapists are increasingly being called upon by the legal system to testify in a professional capacity; either as expert witnesses or factual witnesses. Such requests may be initiated by the client, legal counsel or the court. Interns should consult with their supervisor immediately when they suspect they will be asked to participate in legal proceedings.

The CFT does not offer divorce mediation, child custody evaluations, or litigation support services. Expert witness and legal support services must be performed by a licensed therapist and as such are not consistent within the mission and scope of the CFT.

The CFT does not voluntarily allow the participation of interns in litigation support services. Therefore, interns should discourage their participation in such activities. In the event that client records or an intern is subpoenaed relating to a client, the supervisor of record and clinical director should be notified immediately.

Since interns do not enjoy independent status as mental health professionals, participation in the legal arena requires the active involvement of the intern’s supervisor. The supervisor of record will accompany the intern in the event they are compelled to participate in legal activities (such as depositions or court appearances). It should be clearly communicated to clients that a fee of $100 per hour will be charged for such activities.

Occasionally, requests for legal support services will arise during the course of therapy relating to other treatment concerns. The therapist should consult closely with their supervisor in order to maintain an appropriate therapeutic role with the client.

Clients whose primary request for service is child custody evaluation or litigation support should be referred to a family therapist who offers such services.

Court Mandated Therapy
The CFT works closely with the courts in providing appropriate professional services for adjudicated mandated therapy as a matter between the client and the court. Services will be provided to mandated clients under the same guidelines as with any other client. Interns working with court mandated clients should discuss the referral with the judge or probation officer after reviewing the client referral with their supervisor. Every effort should be made to clarify and assist in meeting the goals of both the referral source and the client in clients involving mandated therapy.

Professional Conduct
General Expectations
While recognizing the differences in style and diversity among individuals, therapists are expected to maintain a professional demeanor in appearance and attitude when operating in a professional role. Students in the CFT program are expected to operate from a primary moral position based on the best interest of the client. This requires, an understanding of appropriate therapeutic roles, therapist’s skills, and limitations pertaining to each client. Interns should be familiar with, and abide by, the codes of ethics of the American Association for Couples and Family Therapy, and the laws of the State of Oregon relating to professional conduct.

Therapist-Client Relationships
The relationship between the therapist and client is unique among human relationships. This relationship entails a basic belief that the therapist’s first obligation is to do no harm to the client through any act of commission or omission. To this end, the purpose and nature of the therapeutic relationship, goals and objectives should be clearly discussed and agreed upon during the initial stages of therapy.

Because of the potential for undue influence or exploitation, dual role relationships should be avoided between the therapist and client. When such dual role relationships become unavoidable (such as church or work contacts), the intern should work closely with their supervisor to minimize the potential for adverse effects.
Faculty-Student and Peer Relationships

Students and faculty are encouraged to develop collegial relationships in order to foster a creative learning environment. Cooperation and collaboration are advocated on professional, educational, and research activities. It is expected that students will work to resolve their differences with each other and faculty/supervisors when they may arise. This involves first addressing differences directly with the intern’s colleague when issues arise. If repeated and determined efforts to resolve the concern by addressing them directly have failed, the intern may decide to approach their individual supervisor to help reach some satisfactory conclusion to the conflict. The supervisor may request a meeting with all involved parties. If repeated and determined efforts to resolve the concern at this level fail to produce a satisfactory outcome, the intern may decide to approach the clinical director. The director may ask for a meeting with all involved parties.

Interns should be aware that the ability to maintain a professional relationship with colleagues and supervisors is an important quality for the intern to possess. If, in the intern is unable to maintain professional working relationship on site, the director may ask to meet with the intern and initiate a remedial plan to overcome any on-site issues related to collegiality and professionalism. The clinical director maintains the option to remove an intern from the internship.
The Center for Family Therapy is a community agency that strives to provide high quality, low cost, individual, couple, and family therapy services. Our clinic is staffed by both national and international graduate interns in the couples and family therapy and counseling psychology programs at the University of Oregon, and they are supervised by the teaching faculty in the program. As a training clinic of the University of Oregon we follow campus policies for diversity and equal opportunity. We are unable to honor client requests for a therapist based on age, gender, national origin, or other protected class (race, disability, sexual orientation, religion). Since we are a learning environment, we record all sessions. These recordings are viewed by therapists and their supervisors only, and are deleted after viewing. Also, the clinic operates on a sliding fee scale and payment is due at the time of each session. The first session is $15 and we use it to determine whether we are a good match for each other. You will fill out some paperwork and the therapist will assess whether we can adequately serve you. Before I take down your information, do you have any questions about the Clinic?

| Your Name: | Date of Birth: / / |
| How do you identify in terms of gender: (Verbatim) |
| Your Phone Number: | Alternative Phone Number(s): |

Reminders: ☐ No - do not call. ☐ Yes - it is ok to call. ☐ No - do not leave message. ☐ Yes - ok to leave message

When is a good time for us to call you? (days/times)

Mailing Address:

How did you find out about our agency?

Are you interested in individual, couples or family therapy?

(For Couple or Family Therapy Only) Who will be attending therapy with you?

(We provide therapy services to minor children; however, proof of legal custody may be required prior to treatment.)

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE OF BIRTH</th>
<th>RELATIONSHIP TO CALLER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What brings you to our Clinic at this time? (i.e., presenting concern; record the caller's verbatim comments and use quotation marks)

How has this affected other people in your life?

Have there been any recent changes or major life events?
Have you been in therapy in the past?

<table>
<thead>
<tr>
<th>When?</th>
<th>With whom?</th>
<th>Reason?</th>
</tr>
</thead>
</table>

Are you able to attend therapy before 5 pm? ☐ Yes ☐ No

(ask this question if there is a sense of risk or danger inherent in the problem statement:
If there is any risk involved in your situation, please give us a sense of how much risk is involved. On a scale of 1-10, with 10 being the highest risk and 1 being the lowest risk, where would you rate your situation?

NOTE ABOUT FEE (please read): Our services are offered on a sliding scale fee basis, payable at the beginning of each session. Fees range from $15 to $100 per session, based on your annual household income. Your therapist will set your fee at the time of your first session. Your first session is $15.

### Sliding Fee Schedule

<table>
<thead>
<tr>
<th>Annual Household Income</th>
<th>Fee</th>
<th>Annual Household Income</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below $15,000</td>
<td>$15</td>
<td>$55,001 - $60,000</td>
<td>$60</td>
</tr>
<tr>
<td>$15,001 - $20,000</td>
<td>$20</td>
<td>$60,001 - $65,000</td>
<td>$65</td>
</tr>
<tr>
<td>$20,001 - $25,000</td>
<td>$25</td>
<td>$65,001 - $70,000</td>
<td>$70</td>
</tr>
<tr>
<td>$25,001 - $30,000</td>
<td>$30</td>
<td>$70,001 - $75,000</td>
<td>$75</td>
</tr>
<tr>
<td>$30,001 - $35,000</td>
<td>$35</td>
<td>$75,001 - $80,000</td>
<td>$80</td>
</tr>
<tr>
<td>$35,001 - $40,000</td>
<td>$40</td>
<td>$80,001 - $85,000</td>
<td>$85</td>
</tr>
<tr>
<td>$40,001 - $45,000</td>
<td>$45</td>
<td>$85,001 - $90,000</td>
<td>$90</td>
</tr>
<tr>
<td>$45,001 - $50,000</td>
<td>$50</td>
<td>$90,001 - $95,000</td>
<td>$95</td>
</tr>
<tr>
<td>$50,001 - $55,000</td>
<td>$55</td>
<td>$95,001 - $100,000</td>
<td>$100</td>
</tr>
</tbody>
</table>

Thank you for your call to us today. One of our therapists will be in contact with you in the next few days to schedule an appointment. If you have not heard from them within the week, please give us a call back.

**Other Useful Information - Community Referrals:**

**Alcohol/Drug Abuse:**
- Emergence: 541-687-9141
- Alcoholics Anonymous: 541-342-4113
- Serenity Lane: 541-687-1110
- Narcotics Anonymous: 541-729-0080

**Children Services:**
- Looking Glass Youth & Family Services: 541-484-4428
- Department of Children and Families Lane County: 541-682-4671

**Crisis Hot Lines**
- White Bird Clinic 24-hour crisis line: 541-687-4000
- Child Abuse Hotline: 541-686-7557
- Looking Glass Youth & Family Services, Inc. (Shelter): 541-689-3111
- Sexual Assault Support Services: 541-343-7277
- Womenspace (Domestic Violence): 541-485-6513
- **Emergency:** 911

**Emergency Rooms**
- McKenzie-Willamette (Springfield): 541-726-4444
- Sacred Heart Medical Center (Eugene): 541-686-6931

*********************************************************************************************************

RED FLAG? ☐ (Please provide intake to clinic manager before assigning therapist or data entry)

**THERAPIST ASSIGNED:** ________________________ ON CARD? ☐ CALLED THERAPIST? ☐

IN TITANIUM SCHEDULE? ☐ IN CFT DATABASE? ☐ Case ID: _________ OQ-45/PDA ID: _________

**THERAPIST NOTES:**

_______________________________________________________________________________________________

_______________________________________________________________________________________________

_______________________________________________________________________________________________

DATE FILED AS “INACTIVE INTAKE”: ___________ THERAPIST SIGNATURE: ________________

{Revised 4/15/2012 Desk Staff → Intern → File}
The services at the Center for Family Therapy will involve discussing psychological, emotional, or relationship issues that may be distressing. This process is intended to help you and, when useful, your relationships with others. Your therapist will provide you with appropriate referrals to other services if needed.

**TREATMENT AT THE CENTER FOR FAMILY THERAPY (CFT)**
- The CFT is a counseling center and training facility of the University of Oregon staffed by graduate student interns who conduct therapy under the supervision of CFT supervisors. Supervisors have advanced degrees and are University of Oregon faculty.
- Therapy sessions are routinely recorded and/or observed by other therapists and supervisors. Information will be shared within the CFT between supervisors and intern therapists for the purposes of assessment, diagnosis, treatment and high quality care. Recordings are not part of the client record and are routinely deleted.
- The CFT is a training clinic for graduate interns from many countries and follows University of Oregon policies for diversity and equal opportunity. Your therapist may be from another country and English may not be his or her native language. Your case will not be transferred to another therapist at the CFT for reasons based on a therapist’s national origin, age, gender, sexual orientation, religion or other protected status. If you are dissatisfied with your therapist, the CFT will be happy to provide referrals to another agency in the community.
- Therapists at the CFT do not provide medical evaluations or prescribe medication. If you are seeking these services, please inform your therapist.
- Information from your therapy may be included in an ongoing pool of research data. This material will not contain your name or other identifying information.
- The CFT does not provide emergency services. Appointments with your therapist will typically occur for 50 minutes on a weekly basis.
- The CFT does not provide psychological evaluations, evidence for disability determination, forensic evaluations (e.g., collecting information in a legal proceeding) or expert testimony for the court. If you are seeking this type of assistance, please inform your therapist.
- The CFT does not routinely release client records. In some circumstances a summary of treatment may be provided. All records requests must be provided in writing, stating the specific information being requested and its intended use. For couples and families, consent must be obtained from all adult members before any records will be released. Records requests may require up to two weeks to process. A fee of $20 will be charged for copying services. Clients must present a state-issued photo I.D. in person when picking up records. Records will not be mailed.
- The CFT interns utilize established, well-known and widely-practiced therapy services. Many clients report that they benefit from CFT services; however, the CFT does not guarantee that any one individual will benefit. Services that are likely to cause harm are not used at the CFT.
- You are free to withdraw from therapy at any time.

**CONFIDENTIALITY AND ITS LIMITS**
- In addition to your therapist, supervisors and other interns, during supervision, will likely become familiar with you and your situation.
- Any supervisor or intern who may know a client outside of the Center (e.g., neighbor, student) will excuse him/herself from all involvement. This is designed to avoid a conflict of interest.
- All information disclosed within sessions is confidential and is not revealed to anyone outside the CFT without your written permission (a *release of information*). The only exceptions to this are required by Oregon law. The primary exceptions include:
  - threat of harm to self
  - threat of harm to others
  - child or elder abuse
  - when ordered by the court

Confidentiality and Relational Therapy
- The Center operates within a “systemic” point of view. We are interested in many aspects of your life – you, your point of view, and your environment.
- Your therapist may ask to meet with you and others in your life in a variety of combinations (e.g., if meeting with a couple, we will likely at times request individual meetings with each partner).
- Information discussed in an individual meeting, if important to the relational therapy, may be discussed in the relational meetings. When a therapist believes that information discussed individually is important for the relational therapy, he/she will:
  - Inform you
  - Discuss with you the information and its importance
  - When appropriate, encourage you to discuss this information openly.
  - Not knowingly surprise you by intentionally disclosing this information without prior notice.
- On occasion, though rarely, a therapist may end services and refer you to another provider if he/she believes the information is essential to discuss, though one party does not agree to do so.
- Information shared in an individual session that, if discussed in a relational session could threaten the safety of either individual, will be handled with care. Protection and safety are above the right to have access to information that is discussed in individual meetings.

I have discussed “*confidentiality and relational therapy*” with my therapist and agree to its conditions. If yes, please initial.

| (initial) | (initial) | (initial) | (initial) |

(Revised 12/2/11: Client ➔ Intern ➔ File)
RESEARCH

- The CFT conducts research based on the results of surveys and interviews completed by its clients.
- Your identity will not be revealed in any report, publication, or presentation without your written consent. Only non-identifying information on recordings is used for research.
- Your information will remain private and your individual responses on questionnaires or interviews will be identified only by a research number and grouped together with the responses of other clients.
- All research staff and volunteers handling your information sign agreements of confidentiality and are trained to respect and maintain client confidentiality.
- You may refuse to allow your information to be used for research at any time.
- Your willingness to provide information for research is entirely voluntary, and your refusal to participate will not prohibit you from receiving services.
- If you have concerns about these rights or how your information is being used, you are free to contact the Office for the Protection of Human Subjects, (541) 346-2510.

CLIENT RIGHTS AND RESPONSIBILITIES

As a client at the Center for Family Therapy you have the following rights and responsibilities as described in the Oregon Administrative Rules (OAR4h):

- To expect that the CFT intern providing your therapy has met the minimal training qualifications as specified by the Commission on Accreditation for Marriage and Family Therapy Education.
- To obtain a copy of the AAMFT Code of Ethics.
- To report concerns and complaints to the Center's Clinical Director.
- 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 and law (for limitations see section on Confidentiality and its Limits)
- To be free from being the object of discrimination on the basis of race, religion, gender, sexual orientation, or other unlawful category while receiving services.

FEE FOR SERVICES

- The charge for your first session is $15.00.
- The CFT offers a sliding scale fee based on annual household income.
- After discussing the sliding scale with your therapist, you agree to pay a fee of $____________ per 50-minute session, payable at the beginning of each session.
- You will be required to pay this 50-minute rate in situations where you fail to cancel or reschedule sessions without giving 24-hour notice.

<table>
<thead>
<tr>
<th>Annual Household Income</th>
<th>Fee</th>
<th>Annual Household Income</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Below $15,000</td>
<td>$15</td>
<td>$35,001 - $40,000</td>
<td>$40</td>
</tr>
<tr>
<td>$15,001 - $20,000</td>
<td>$20</td>
<td>$40,001 - $45,000</td>
<td>$45</td>
</tr>
<tr>
<td>$20,001 - $25,000</td>
<td>$25</td>
<td>$45,001 - $50,000</td>
<td>$50</td>
</tr>
<tr>
<td>$25,001 - $30,000</td>
<td>$30</td>
<td>$50,001 - $55,000</td>
<td>$55</td>
</tr>
<tr>
<td>$30,001 - $35,000</td>
<td>$35</td>
<td>$55,001 - $60,000</td>
<td>$60</td>
</tr>
</tbody>
</table>

I have discussed the above section with my therapist and have indicated below any materials that I do not want the CFT to use for research.

Please do not use the following for research:

| Intake Information & Questionnaires |   |   |   |
| Video of Sessions                 |   |   |   |
| Follow-up interviews              |   |   |   |

I have reviewed this consent form and my therapist has answered all of my questions about treatment with the Center for Family Therapy satisfactorily. If I have further questions I understand that my therapist will either answer them, find answers for me, and that I can contact the CFT Director, Tiffany Brown, at (541) 346-2117. I understand that I may leave therapy at any time, although I understand that this is best accomplished in consultation with my therapist.

Signed:_____________________________________________ Date:____________________
Signed:_____________________________________________ Date:____________________
Signed:_____________________________________________ Date:____________________
Signed:_____________________________________________ Date:____________________
Signed:_____________________________________________ Date:____________________

(Revised 12/2/11: Client → Intern → File)
Welcome to the *Center for Family Therapy*. Please take a few minutes to complete this form before meeting with your therapist. When you are done filling out the information, bring the form to the person at the counter or to your therapist. If you have any questions about this form or don’t know what to write, please feel free to leave the space blank until you meet with your therapist.

**Today’s Date:** __________________________

**Information About You:**

<table>
<thead>
<tr>
<th>First Name:</th>
<th>Middle:</th>
<th>Last Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth <em>(mm/dd/yyyy)</em>:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone Number(s) <em>(home, cell, work)</em>:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

- [ ] Check here if it’s ok for your therapist to call you here
- [ ] Check here if it’s ok for your therapist to leave messages here

<table>
<thead>
<tr>
<th>Is there anything we need to know about contacting you at this number?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Street Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact Name:</th>
<th>Relationship to You:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact Phone Number(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Providers’ Name(s)/Phone Number(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Medications:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Have you seen a counselor/therapist in the past? [Y] [N] <em>(if yes, please provide the name or agency)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you currently seeing another counselor/therapist? [Y] [N] <em>(if yes, please provide the name/agency and phone no.)</em></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| If you have been in counseling or therapy in the past, what was helpful? What was not helpful? |
|                                                                                            |

<table>
<thead>
<tr>
<th>Do you know anyone currently being seen at this clinic?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If yes, what is their relationship to you?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
Age: ____________

Gender:
1 Female
2 Male
3 Trans: [specify ______________________________]
4 Other: [specify ______________________________]

Ethnic/Cultural Background:
1 African-American
2 American Native/Alaskan Native
   2a Tribal Member? □ Y □ N
2b Tribe: _________________________________
3 Asian/Pacific Islander
4 Latino/Latina/Hispanic
5 Mixed Race [specify ______________________________]
6 White
7 Other: [specify ______________________________]
8 Country of Origin: [specify ______________________________]

Primary Religious/Spiritual Orientation:
1 Buddhist
2 Christian
3 Hindu
4 Jewish
5 Muslim
6 Other: [specify ______________________________]
7 None

Sexual Orientation:
1 Gay
2 Lesbian
3 Bisexual
4 Heterosexual
5 Other: [specify ______________________________]

Veteran: □ Yes □ No

Disabled: Please list any disability that you may have that you would like us to know about: ______________________________

Relationship Status:
1 Single
2 Married/Common Law/Domestic Partnership
3 Divorced
4 Widowed
5 Partner/Significant Other
6 Separated

Number of Children (please circle one):
0 1 2 3 4 5-7 more than 7

Language Spoken in Home:
1 English
2 Spanish
3 Chinese
4 Japanese
5 Other: [specify ______________________________]

Highest level of education completed:
1 11th grade/under
2 High school diploma/GED/Voc/Tech.
3 Some college or AA degree
4 BA/BS degree
5 Graduate degree

Current source(s) of household income:
1 Earned income from employment
2 Unemployment benefits
3 SSI/SSDI
4 Welfare/AFDC
5 Retirement/pension
6 Child support
7 No source at this time
8 Other [specify ______________________________]

Employment Status:
1 Employed full-time (36 hrs. or more per week)
2 Employed part-time (less than 36 hrs. per week)
3 Unemployed
4 Student
5 Other [specify ______________________________]

Household pre-tax annual income:
1 $0 7 $35,001-$40,000
2 under $6,000 8 $40,001-$45,000
3 $6,000 to $15,000 9 $45,001-$50,000
4 $15,001 to $20,000 10 $50,001-$55,000
5 $20,001 to $25,000 11 $55,000-$60,000
6 $25,001 to $30,000 12 $60,000 +
7 $30,000-$35,000 13 unknown

Number of people in household (please circle one):
1 2 3 4 5-7 more than 7

Occupation: ______________________________________

Other Information
Who lives in your home and what is their relationship to you?

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>1</td>
<td>Have you or anyone close to you had any recent changes, such as job loss, recent moves, etc.?</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Have there been any recent deaths or losses in your family or among your friends?</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>Are you or is anyone close to you currently dealing with any medical concerns?</td>
<td>Yes</td>
</tr>
<tr>
<td>4</td>
<td>Are you currently or have you ever been involved with Child Protective Services?</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>Have you ever participated in any support group and/or counseling – or considered being involved – due to your use or someone else’s use of alcohol or other drugs?</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>Has any aspect of your life or those around you been negatively impacted at any time due to your use of other drugs?</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>Has any one ever expressed a concern about your use of alcohol or other drugs, including prescription medication and supplements?</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>Have you at any time in your life been concerned about your use of alcohol or other drugs, including prescription medication and supplements?</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>Do you have any concerns with your current diet and exercise patterns?</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>Are you currently, or have you ever, utilized self-harming behaviors (i.e., cutting yourself, banging your head, burning yourself) as a means of an emotional release or punishment, or for other reasons?</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>When gambling, have you ever felt the need to bet more and more money?</td>
<td>Yes</td>
</tr>
<tr>
<td>12</td>
<td>Have you ever had to lie to people important to you about how much you gambled?</td>
<td>Yes</td>
</tr>
<tr>
<td>13</td>
<td>At any time during your childhood did you see or hear someone in your household being physically harmed?</td>
<td>Yes</td>
</tr>
<tr>
<td>14</td>
<td>Have you ever been emotionally mistreated in a significant and ongoing way by an intimate partner, such as being told you were ugly or stupid, or being restricted from activities that are very important to you?</td>
<td>Yes</td>
</tr>
<tr>
<td>15</td>
<td>Have you ever been made to have some form of unwanted sexual contact?</td>
<td>Yes</td>
</tr>
<tr>
<td>16</td>
<td>Have you at any time felt afraid due to behavior by an intimate partner (e.g., spouse, boyfriend, girlfriend) or former intimate partner?</td>
<td>Yes</td>
</tr>
<tr>
<td>17</td>
<td>Are you experiencing any difficulties in the following areas (please check all that apply):</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alertness</td>
<td>Depression/Sadness</td>
</tr>
<tr>
<td></td>
<td>Appetite</td>
<td>Dizziness/Faintness</td>
</tr>
<tr>
<td></td>
<td>Body image concerns</td>
<td>Headaches</td>
</tr>
<tr>
<td></td>
<td>Breathing</td>
<td>Memory</td>
</tr>
<tr>
<td></td>
<td>Concentration</td>
<td>Nightmares</td>
</tr>
<tr>
<td></td>
<td>Conflict in current relationship</td>
<td>Numbness</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>My efforts in working with my therapist at the Center for Family Therapy will likely be useful for me.</td>
<td>Strongly Agree</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Children in Therapy**

<table>
<thead>
<tr>
<th>Please list all minor children (under 18) who will be participating in therapy with you:</th>
<th>I have the legal right to give permission for therapy services, because my relationship to the child is (check one):</th>
<th>Name of Child’s School:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Custodial parent ☐ Legal guardian ☐ DHS or OYA caseworker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Custodial parent ☐ Legal guardian ☐ DHS or OYA caseworker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Custodial parent ☐ Legal guardian ☐ DHS or OYA caseworker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Custodial parent ☐ Legal guardian ☐ DHS or OYA caseworker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Custodial parent ☐ Legal guardian ☐ DHS or OYA caseworker</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**About Your Reason for Contacting the CFT**

Please describe your reason for seeking counseling at this time.

Who is involved and/or aware of these factors in your life?

Whatever your reason(s) for seeking counseling, how long has this influenced you/your life?

What have you tried to do to resolve these matters on your own? In what way(s) was this helpful?

What are your thoughts about how we might be of help?

What have we not asked about that you would like your therapist to know?

Thank you for taking the time to fill this out. Please bring this form to the person at the front desk and your therapist will be out to greet you soon.

{Revised 11/14/2011: Client → Intern → Desk Staff → Intern → File}
<table>
<thead>
<tr>
<th>DATE</th>
<th>SESSION: #, TYPE, MINUTES</th>
<th>NOTES: CLIENTS PRESENT-ISSUES/SYMPTOMS/INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Suicidal/Homicidal Ideations/Any Referrals/Supervised Session
The purpose of this form is to denote the completion of therapy or to transfer the client(s) to a new therapist. This form should be completed at the time of completed therapy by the current primary therapist.

Therapist Name: Client Code:

Intake Date: Transfer / Completion Date:

Address & Phone:

Number of Total Sessions:

1. Main reason for transfer/completion of services:
   - The completion of one or more therapeutic goals
   - The client(s) no longer participating in therapy (notes should reflect attempts to contact client)
   - Client was unable to afford therapy or did not pay past due bills
   - There was little or no progress in therapy
   - This is a planned pause in therapy
   - The client(s) needs services not available here and was referred to: _________________________
   - (Transfer) Therapist is leaving agency and a new therapist has been assigned: _________________________
   - Other (please explain): ________________________________________________________________

2. List the presenting concerns discussed in therapy and their outcomes:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Therapist Signature: _______________________________ Date:________________________________

Supervisor Signature: ______________________________ Date:________________________________
HEDCO CLINIC
AUTHORIZATION TO USE AND DISCLOSE INFORMATION

Client Name: _________________________________  Birth Date: ______________  Phone #: __________________

I authorize:
☒ Center for Family Therapy
☒ Counseling Psychology Clinic
☒ CTL Reading Clinic
☒ School Psychology Clinic
☒ Speech-Language-Hearing Center

OR
☒ This other entity (name/address /telephone of disclosing entity)

HEDCO Clinic
5207 University of Oregon
Eugene, OR 97403-5207

To use and/or disclose a copy of the information described below for the above-named client

Information is to be received and used by:
☒ Center for Family Therapy
☒ Counseling Psychology Clinic
☒ CTL Reading Clinic
☒ School Psychology Clinic
☒ Speech-Language-Hearing Center

OR
☒ This other entity (name/address /telephone of receiving entity)

HEDCO Clinic
5207 University of Oregon
Eugene, OR 97403-5207

For the purpose(s) of:
☒ At the request of the client or legal/personal representative
☒ Referral
☒ Case Coordination
☒ Consultation
☒ Other purposes (specify each purpose):

Purpose

For the purpose(s) of:

Description or nature of information to be used and/or disclosed: (initial all that apply)

☐ Contact Information
☐ Educational records and assessments
☐ Goals and Objectives
☐ Treatment/Progress Summary
☐ Treatment Notes
☐ Social History
☐ Other: ______________________________

Diagnostic Evaluation
☐ Audiology Report
☐ Neuropsychology Report
☐ Otolaryngology Report
☐ Physician’s Report

Records for the following dates or treatment:

Specially Protected Information:
If the information to be disclosed contains any of these types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

☐ Mental health treatment records
☐ Drug/Alcohol abuse diagnosis, treatment, & referral records
☐ Information re: HIV/AIDS/Sexually transmitted diseases
☐ Information re: Genetic testing (Oregon)
1. I understand that I do not need to sign this authorization. Refusal to sign will not adversely affect my ability to receive services or reimbursement for services. The only circumstance when refusal to sign means I will not receive services is if the services are solely for the purpose of providing information to someone else and the authorization is necessary to make that disclosure.

2. I may revoke this authorization in writing at any time. If I revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, I must send a written statement to the clinic manager at the HEDCO Clinic, 5207 University of Oregon, Eugene Oregon 97403-5207, and state that I am revoking this authorization.

Unless revoked, this authorization is valid for:
- One year from the date of signature below
- Upon termination/completion of services
- For the following specific time period:
  Beginning date: ___________________________ Ending (expiration) date: ___________________________

SIGNATURE:
I have read this authorization, and I understand it.

Signature of Client or legal/personal representative ___________________________ Date ___________________________

Description of personal representative’s authority:
_________________________________________________________________________________________
The purpose of this form is to clarify and document the nature of the presenting concern/expressed need and the plan developed collaboratively by the therapist and the client(s) to bring about change. This plan is an essential part of the service/treatment dialogue, provides direction, and is a basis for measuring change. Complete sections 1-4 along with client goals, objectives and activities by the 4th session. Revise as essential developments/changes occur.

Therapist Name: 
Client Code: 
Date of 1st Appointment: 
# of Clients involved, initially: 

1. Expressed need/presenting concern (including direct client statements; represent each client’s perspective).

2. Essential contextual information (e.g., circumstances relevant to expressed/presenting concern; diversity, spirituality/religious affiliation). Note: Genogram information pertains to this section. Include on backside of page or separate sheet of paper.

3. Client resources, assets and interests/activities.

4. Action Map/Central Process: 
   Briefly describe and diagram the typical sequence of events that encapsulates/surounds the expressed need/presenting concern(s).
**CLIENT GOALS**
What is the consensus view of what will be occurring (cognitive, behavioral, interpersonal) when desired change is achieved? Express these changes in vivid, tangible cognitive and behavioral language – stated positively, i.e., what will be occurring when the expressed need(s)/presenting concern(s) is adequately changed. These goals should be articulated by the fourth session. As treatment progresses, modify and add to goals as needed.

1. 

2. 

3. 

**INTERMEDIATE OBJECTIVES**
List the indicators of change that will occur prior to achieving the goals listed above. Intermediate objectives are essential changes that create the conditions for achieving longer-term goals. For example, to reduce high-conflict symmetrical escalations, each member of the couple may benefit from successful implementation of self-soothing strategies. List at least two objectives for each goal stated above. And, list key therapist interventions and client activities that will facilitate achievement of the objectives. This section should be completed by the fourth session.

<table>
<thead>
<tr>
<th>GOAL #1</th>
<th>Interventions &amp; Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 1</strong></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td><strong>Objective 2</strong></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td>GOAL #2</td>
<td>Interventions &amp; Activities</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Objective 1</strong></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td><strong>Objective 2</strong></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td>GOAL #3</td>
<td>Interventions &amp; Activities</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------</td>
</tr>
<tr>
<td><strong>Objective 1</strong></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td><strong>Objective 2</strong></td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
</tbody>
</table>

Therapist Signature: ___________________________ Date ________________

Supervisor Signature: ___________________________ Date ________________
**Treatment Plan Revisions**
Document significant revisions relative to the treatment plan (e.g., revisions or additions to initial goals and objectives).

<table>
<thead>
<tr>
<th>GOAL #1</th>
<th>Interventions &amp; Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1</td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td>Objective 2</td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL #2</th>
<th>Interventions &amp; Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1</td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td>Objective 2</td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GOAL #3</th>
<th>Interventions &amp; Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1</td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
<tr>
<td>Objective 2</td>
<td>a.</td>
</tr>
<tr>
<td></td>
<td>b.</td>
</tr>
<tr>
<td></td>
<td>c.</td>
</tr>
</tbody>
</table>

Therapist Signature: __________________________ Date_________________________

Supervisor Signature: __________________________ Date_________________________
At the Center for Family Therapy we believe in seeing people in therapy only as long as it is apparent that they are experiencing clear benefits from the service. This is usually best accomplished if there are understandable goals established early in the therapy process that are discussed and agreed to by both you and your therapist. We have found it is useful to identify and plainly spell out therapy goals. It is the therapist’s responsibility to draw attention to these issues if it is unclear that you are benefiting from services. We encourage you to also tell your therapist if you do not believe you are benefiting from your work together.

**Typical elements in effective therapy:**

1. A supportive relationship actively working toward desired changes.
2. Direct conversations about desired changes, including therapist recommendations for change and your thoughts and feelings about those recommendations.
3. Seeking additional support services when the therapist views them as necessary for successful treatment and ongoing conversation about your thoughts and feelings about those additional services.
4. Paying for services when they are rendered.
5. Attending regularly scheduled appointments, and if cancelling is necessary, providing 24-hour notice. It is important for your relationship with your therapist to clearly communicate any expected absences prior to the scheduled appointment. Failure to show up for scheduled appointments can be detrimental to effective therapy. Regularly attending sessions is typically an important aspect of making progress toward positive changes.

**Typical reasons for ending therapy:**

6. The goals of therapy have been accomplished and you and your therapist agree to end treatment.
7. You and/or your therapist believe that you are not benefiting from therapy after reasonable efforts have been made to address your needs. Should this occur, we will work with you to identify a more useful approach for your particular circumstances.

I have read and understand the Beneficial Services Agreement. My signature indicates that I agree with the ideas overall and I agree to discuss with my therapist any concerns I may have about progress toward my desired changes.

<table>
<thead>
<tr>
<th>Client Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Signature:</td>
<td>Date:</td>
</tr>
<tr>
<td>Client Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>
--- Community Resources ---

### Emergency 911

#### Hospital Emergency Rooms
- Eugene Sacred Heart Medical Center: (541) 686-6868
- Springfield McKenzie-Willamette: (541) 726-4444

#### General Crisis Lines
- White Bird Crisis Service Center: (541) 687-4000, Local; 24-hour Crisis Line & Walk-in Crisis Service Center, 341 E.12th St.
- Looking Glass Youth & Family Services, Inc.: (541) 689-3111, 24-hour Crisis Line Shelter
- Community Sharing Helpline, South Lane County- Cottage Grove: (541) 942-2176
- Focus 4 Crisis Line, Siuslaw Area- Florence/Mapleton: (541) 997-4444
- National Hopeline Network: (800) 784-2433
- National Suicide Prevention Lifeline: (800)273-8255

#### Population-Specific Crisis Lines
- Sexual Assault Support Services: (541) 343-7277, Local; Sexual Assaults/Abuse, 24-hour Crisis Line & Walk-in Support, Advocacy Center (M-F, 9a-4p), 591 W.19th Ave
- Womenspace: (541) 485-6513, Local; Domestic Violence; 24-hour Crisis Line
- Youth Hopeline: (877) 553-8336, National; Peer-to-peer crisis line for teens
- Gay & Lesbian National Hotline: (888) 843-4564, National; GLBT, (EST M-F, 4p-midnight / Sat,12-5p)

#### Alcohol / Drug / Gambling
- Addiction Counseling and Educational Services, Inc: (541) 342-6987, Alcohol, drug & gambling addictions
- Alcoholics Anonymous: (541) 342-4113
- Narcotics Anonymous: (541) 729-0080
- Serenity Lane Treatment Center: (541) 687-1110, Alcohol & drug addictions
- Looking Glass Adolescence Recovery Program: (541) 485-8448
- Drug & Alcohol Hopeline: (800) 923-4673, National

#### Children Services
- DHS: Child Welfare Program (Child Protective Services): 686-7555

#### Consumer Services
- Consumer Credit Counseling Services: 342-4459

(Revised 6/9/2011)
The purpose of this form is to document any significant contact between parties involved with the case. This should include therapy sessions, telephone contact with the client, contact between the therapist and the client’s physician, meetings with supervisor, no-shows, client cancellations etc.

<table>
<thead>
<tr>
<th>Therapist Name:</th>
<th>Client Name(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake Date:</td>
<td>Client Code:</td>
</tr>
<tr>
<td>Phone Numbers:</td>
<td>Okay to leave message?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE (include year)</th>
<th>SESSION NUMBER*/TYPE OF CONTACT (i.e., Telephone contact with client, telephone contact with physician, etc.) * Note: OQ to be given at the 1st, 3rd, 5th, 10th and subsequent 10th sessions.</th>
<th>RELEVANT CONTACT INFORMATION (i.e. current phone numbers, addresses, etc.)</th>
<th>OUTCOME or DISPOSITION OF CONTACT (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DATE (include year)</td>
<td>SESSION NUMBER*/TYPE OF CONTACT (i.e., Telephone contact with client, telephone contact with physician, etc.) * Note: OQ to be given at the 1&lt;sup&gt;st&lt;/sup&gt;, 3&lt;sup&gt;rd&lt;/sup&gt;, 5&lt;sup&gt;th&lt;/sup&gt;, 10&lt;sup&gt;th&lt;/sup&gt; and subsequent 10&lt;sup&gt;th&lt;/sup&gt; sessions.</td>
<td>RELEVANT CONTACT INFORMATION (i.e. current phone numbers, addresses, etc.)</td>
<td>OUTCOME or DISPOSITION OF CONTACT (if any)</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Client Self-Care Plan

I, _____________ agree to do the following things to take care of myself for the following specified time: _________________.

☐ __________________________________________________________________________
☐ __________________________________________________________________________
☐ __________________________________________________________________________
☐ __________________________________________________________________________
☐ __________________________________________________________________________
☐ __________________________________________________________________________
☐ __________________________________________________________________________
☐ __________________________________________________________________________

Client Signature: ____________________________________________________________
Therapist Signature: _______________________________________________________
Date: ______________________________________________________________________

Crisis Hot Lines
White Bird Clinic (24 hour crisis line) .................................................687-4000
Women Space (domestic violence) ............................................................485-6513
Sexual Assault Support Services.............................343-SASS/1-800-788-4727
Looking Glass Youth & Family Services, Inc. (shelter)... 689-3111

Emergency (911)

Hospitals/Emergency Rooms
McKenzie-Willamette (Springfield) .........................................................726-4444
Sacred Heart (Eugene) .................................................................686-6868
No Harm Contract

I, ____________________________________________, agree that I will not do anything that would cause harm to myself or anyone else for the following specified time: ____________________________.

If I am having difficulty maintaining this contract, I agree that I will meet face to face with my therapist in order to discuss the situation. If I am initially unable to reach my therapist, I will utilize one of the resources listed below until I am able to meet with my therapist. I will also contact other sources of support listed below.

________________________________________________________________________
________________________________________________________________________

Signature: _____________________________________________________________

Witness: ______________________________________________________________

Date: ____________________________

Crisis Hot Lines
Looking Glass Youth & Family Services, Inc. (Shelter). .......................... 689-3111
Sexual Assault Support Services. .................................................. 343-SASS/1-800-788-4727
Womenspace (Domestic Violence). ..................................................... 485-6513
White Bird Clinic – 24 hour crisis line. .................................................. 687-4000

Emergency (911)

Hospitals (Emergency Rooms)
McKenzie-Willamette (Springfield). ...................................................... 726-4444
Sacred Heart Medical Center (Eugene). ................................................ 686-6868

{Revised 4/27/09: Intern ➔ Client (copy) ➔ File (orig.)}
CENTER FOR FAMILY THERAPY

TIME-OUT CONTRACT

I, _________________________, agree to use time out procedures to maintain my safety and control of my behavior. I agree that I will only use time out for myself and will not call time out on my partner. Furthermore, I agree that I will follow the negotiated time-out procedure outlined below. I understand that time out procedures are intended to maintain safety and are not to be used to avoid discussions or control my partner.

I, _________________________, agree to use time out procedures to maintain my safety and control of my behavior. I agree that I will only use time out for myself and will not call time out on my partner. Furthermore, I agree that I will follow the negotiated time-out procedure outlined below. I understand that time out procedures are intended to maintain safety and are not to be used to avoid discussions or control my partner.

Signal
The agreed upon signal for initiating a time out is: ________________________________________
(Signals should be non verbal, i.e. a hand gesture, and non-threatening)

Location
After signaling for a time-out, ____________ will leave and go to _____________________________.

After signaling for a time-out, ____________ will leave and go to _____________________________.

(The time-out location should not be a common area, such as the bedroom, or a location that will increase anxiety, i.e. a bar)

Time
_______________ will spend _____ minutes at the designated time out location. At the end of this time period, I will reconnect with my partner using one of the reconnection strategies listed below.

_______________ will spend _____ minutes at the designated time out location. At the end of this time period, I will reconnect with my partner using one of the reconnection strategies listed below.

(Choose a length of time that will allow you to cool off or feel safe. The length of time is generally between 10 and 30 minutes)

Reconnection Strategies

- **Call another time-out.** If I continue to feel unsafe or at risk of losing control after taking a time-out, I will reconnect with my partner and let them know I need another time-out.
- **Continue the discussion.** After taking a time-out, I will reconnect with my partner and continue the discussion. If I again feel unsafe or at risk of losing control, I will call another time-out.
- **Agree to table the discussion.** After taking a time out, I will reconnect with my partner. We may agree to postpone the discussion until a more convenient or appropriate time.
- **Agree to drop the discussion.** After taking a time-out, I will reconnect with my partner. We may agree that the discussion was or is no longer relevant and let it go.
I pledge to never allow my anger to go to the point where I forcefully touch another family member, or verbally or emotionally abuse another family member, no matter how right I feel I am.

I pledge to use timeout procedure instead, and to cooperate whenever my partner initiates a time-out.

_____________________________________                   ______________
Client Signature       Date

_____________________________________                   ______________
Client Signature       Date

_____________________________________                   ______________
Witness Signature       Date
Therapists use this form any time there is a change in client information, such as case type, transfer, or contact information. Place form in Data Entry File in records room or give to front desk staff.

Data Entry Request

Please place slip in Data Entry file in Admin drawer when completed.

Therapist Name: ____________________________

Date: ______________ File Code: ______________

Case ID #: __________ Current Case Type: ______
(Individual / Couple / Family)

☐ Change in case type. This case is now (check one):
  o Individual
  o Couple (Please include Client Questionnaire for new client in file.)
  o Family (Please include Client Questionnaire for new clients in file.)

☐ Change in contact information:
  o New phone: __________________________
  o New address: _________________________
  __________________________
  __________________________

☐ Change in therapist. This case is being transferred to: ________________________

☐ Addition of a co-therapist: __________________________

☐ Other (please specify data change):
  ______________________________________
  ______________________________________
  ______________________________________
  ______________________________________

Desk Staff Name: ____________________________

Date: _____________________________________

☐ Titanium
☐ Database
☐ OQ Analyst

☐ Data entry has been completed (please place slip in therapist’s message box).
ACKNOWLEDGMENT OF RECEIPT and
THOROUGH REVIEW OF CENTER FOR FAMILY
THERAPY POLICIES AND PROCEDURES MANUAL

TO BE COMPLETED BY THE PRACTICUM STUDENT AND
RETURNED TO THE PROGRAM CLINICAL DIRECTOR

My signature below acknowledges that I have received
the Couples and Family Therapy Program CENTER FOR
FAMILY THERAPY POLICIES AND PROCEDURES
MANUAL as of this date. I agree to read the entire
manual and have all of my questions answered before I
begin my practicum. If I have any questions I agree
that I will contact my supervisor or the clinical
director and have my questions answered before taking
any action. I further agree to return this form to the
program clinical director on this date.

___________________________________________________
Student’s Printed Name  Student ID#

___________________________________________________
Phone  Email

___________________________________________________
Student Signature  Date