



Hilary Kinavey, MS, LPC

Be Nourished
3719 N. Williams
Portland, OR 97227
503-288-4104

Philosophy and Approach: I believe that all people have an inherent capacity for personal growth and change, and counseling can be an integral tool in that process. As a counselor, I work in partnership with clients to develop a deeper understanding of individual strengths, personal challenges and inner wisdom. My approach is eclectic and I draw upon systemic, psychodynamic, cognitive-behavioral and solution focused modalities of treatment. I have professional training and experience working with eating disorders and obesity, anxiety and depression, trauma and PTSD, compulsive and/or addictive behaviors, self-esteem and sexuality. I am trained in EMDR (Phase I and II).

Formal Education and Training: I received my Master's degree in Community Counseling from Portland State University in June, 2000. I have an additional graduate certificate in Marriage and Family Counseling.

As a Licensee of the Oregon Board of Licensed Professional Counselors and Therapists, I will abide by its Code of Ethics. To maintain my license I am required to participate in annual continuing education, taking classes dealing with subjects relevant to this profession. I may substitute professional supervision for part of this requirement.

Fees: My fee is \$135.00 for the initial session and \$105 for follow up sessions. I request 24 hour notification is a scheduled appointment is cancelled. If 24 hour notice is not provided, I ask the client to be responsible for paying for the missed session.

As a client of an Oregon licensee you have the following rights:

1. To expect that a licensee has met the minimal qualifications of training and experience required by state law;
2. To examine public records maintained by the Board and to have the Board confirm credentials of a licensee;
3. To obtain a copy of the Code of Ethics;
4. To report complaints to the Board;
5. To be informed of the cost of professional services before receiving the services;
6. To be assured of privacy and confidentiality while receiving services as defined by rule and law, including the following exceptions: a) Reporting suspected child abuse; b) Reporting imminent danger to client or others; c) Reporting information required in court proceedings or by client's insurance company, or other relevant agencies; d) Providing information concerning licensee case consultation or supervision; and e) Defending claims brought by client against licensee;
7. To be free from being the object of discrimination on the basis of race, religion, gender, or other unlawful category while receiving services.

Board office name, address and telephone number.

You may contact the Board of Licensed Professional Counselors and Therapists at 3218 Pringle Rd SE #250, Salem, OR 97302-6312 Telephone: (503) 378-5499



Hilary Kinavey, MS, LPC

Client Information

Name: _____ SS# _____
(For insurance purposes only)

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work Phone: _____

Email Address: _____

Date of Birth: _____

How did you hear about me or Be Nourished? _____

May I thank the person who referred you? _____

Emergency Contact: _____ Phone: _____
(this might be a partner, friend or family member)

Your employer (if applicable) _____

Current prescription drugs: _____

Other health treatments: _____

What brought you here? _____

What do you hope to accomplish during our time working together? _____



Hilary Kinavey, MS, LPC

Insurance Information

Please skip this portion if paying out of pocket

Insurance Provider: _____

Phone # _____ Fax # _____

Policy # _____ Group # _____

Name of Primary Insured Person on your policy _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS- See also "Consent to use & disclose your health info"

- I hereby authorize the provider to furnish my insurance company with all information requested concerning my present claim.
- I acknowledge that I am responsible for all charges not covered by insurance.
- I agree to pay in full for services leading to written reports prior to their release.
- I authorize payment of benefits from my insurance provider to Hilary Kinavey, MS, LPC.

Client signature _____

Today's Date: _____



Hilary Kinavey, MS, LPC

Agreements for Working Together

1. Sessions will typically be 50 minutes in length, including time for payment and scheduling unless a longer appointment is requested and scheduled.
2. I agree to pay \$125 for our initial session and \$95 for all sessions following unless otherwise noted.
3. I agree to pay at the time of service for my full session or my co-payment.
4. I am available by phone and email between sessions if a crisis emerges. I will return all calls and emails as promptly as possible. You can expect a return call or email from me within normal business hours.
5. I understand I will be charged for emergency telephone consultations exceeding 15 minutes at the office hourly rate.
6. I understand that I will be **charged my full hourly fee** for sessions cancelled with less than **24 hours notice** in advance of my session. Exceptions to this policy are cases where sudden illness and legitimate emergencies occur. My insurance will not pay for missed sessions.
7. I agree to return any money owed to Hilary Kinavey, MS, LPC received from my insurance company. Blue Cross reimburses the insured directly when services are rendered by a non-participating provider.
8. I understand that any money in excess of my bill will be returned to me from insurance reimbursement.

I have read and agree to the following policies.

Signature: _____



Hilary Kinavey, MS, LPC

Date: _____

Be Nourished

www.benourished.org 503-288-4104

We are very concerned about protecting your privacy, because complete confidentiality is necessary for effective therapy. This standardized HIPAA document has some confusing language in it. Please be sure to bring up any questions you may have about this form.


Consent to Use and Disclose Your Health Information

This form is an agreement between you and Be Nourished.

When we examine, test, diagnose, treat, or refer you we will be collecting what the law calls Protected Healthcare Information (PHI) about you. We need to use this information to decide on what treatment is best for you, and to provide any treatment to you. With your permission, we may also share this information with others who provide treatment or need it to arrange payment for your treatment.

By signing this form you are agreeing to let us use your information here and send it to others, including billing and book-keeping personnel who also honor confidentiality policies. Our formal Notice of Privacy Practices explains your rights in more detail and how we can use and share your information. If you would like to read the Notice before you sign this Consent form, you may.

If you send us e-mail, it is with the understanding that this is not necessarily a secure means of communicating confidential information. We would only initiate email contact with you as a way of letting you know of educational events or community gatherings we offer that may be of interest. We would not release your e-mail address to anyone, ever. We may handle calls on a cell or cordless phone that is not a protected means of communication. Please let us know if this is a cause for concern.

Please **INITIAL** to permit us to thank a referral source for sending you here. _____ 

In the future, we may change how we use and share your information and so may change our Notice of Privacy Practices. If we do change it, you can get it from our website, or by calling us at (503) 295-6265, or from your counselor.

If you wish, you have the right to ask us not to share your information. Just tell us what you want in writing. After you have signed this consent, you have the right to revoke it, by writing a letter to your counselor telling us you no longer consent. We will comply with your wishes about sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

Signature of client or his or her personal representative
(Guardian or parent of minor)

Date

Printed name of client or personal representative

Relationship to the client



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Hilary Kinavey, MS, LPC

Signature of counselor

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Name: _____ **Date** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____

Email address: _____ **Date of Birth:** _____

How did you hear about our services? _____

May we thank the person who referred you? _____

Would you like to receive our monthly email newsletter? _____

For Office Use Only:

Therapist: _____ **Group:** _____ **WP:** _____