CLIENT POLICIES AND INFORMED CONSENT

Please read this information carefully and let me know if you have any questions or concerns.

APPOINTMENTS

- Your initial session is considered an evaluation and will last approximately one hour. Subsequent sessions are 45-50 minutes long.
- If you need to change or cancel an appointment, 24 hours notice is required, otherwise you will be charged a $40 fee for that session. Your insurance company will not cover a missed appointment. You may change or cancel an appointment by leaving a message on my voice mail.

CONFIDENTIALITY

All information you share with me remains confidential. However, there are a few exceptions to this rule:

- Oregon law requires exceptions to confidentiality if:
  - If I am ordered by a judge to share information with the court
  - If I believe you are a physical danger to yourself or others
  - If physical or sexual abuse of a child or an elderly person is suspected or reported to me
  - I may have to release clinical information regarding you to insurance carriers as required for authorization of treatment, payment, or review of your claim.
- I may ask you to sign an Authorization for Release of Information so that I can discuss your treatment with your physician, previous therapist, or another person or professional involved in your care.
- I may consult with colleagues about my work or in my teaching and supervision of other mental health professionals. If your case is discussed, it will be confidential and without your name or identifying information.

CLIENTS RIGHTS AND RESPONSIBILITIES

Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods of therapy which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment, to end treatment at any time, or to request a referral to another therapist.

HEALTH INSURANCE

If you are using a health insurance benefit as payment for these services you need to be aware of what this may mean. Most insurance companies require clinical information in order to authorize and/or pay your claim. Health insurance companies usually limit mental health coverage to services that are medically necessary. This typically means there is evidence of a diagnosis with acute symptoms. Furthermore, a utilization review/quality assurance group set up by the insurance company or a peer supervision group may review your case or file. In such a situation, your name and identifying information will be kept confidential.

INSURANCE BILLING POLICIES

As a preferred provider with Regence Blue Cross of Oregon, Providence Health Plan, ProvidencePreferred, Lifewise, ODS, Kaiser, United Behavioral Health, Aetna, Pacificare, PacificSource, Great West, CCN and ValueOptions, I have agreed to bill these companies directly for my services. If you are insured through one of these companies, you are still responsible for your co-payment and any deductible you may have at the time of services. Please familiarize yourself with your coverage before your first appointment, and check to see if your policy requires preauthorization.
With other insurance companies, I will gladly file a claim for you with your insurance company, but I may require that you pay the full fee at the time of your session and have the insurance company reimburse you. If this presents a problem for you, please let me know so we can discuss other arrangements. In any case, you will be responsible for paying any claim that your insurance denies.

OUTCOME MEASUREMENT

A growing body of research suggests that routine and frequent use of outcome questionnaires is associated with better treatment outcomes. Information from the questionnaires help the clinician and client monitor improvement and make adjustments in the treatment plan as necessary. For this reason, I may periodically ask you to complete a brief questionnaire as part of your treatment. Please respond as honestly as possible because this will help me evaluate if the treatment is effective for you. I subscribe to an outcomes measurement service (The Center for Clinical Informatics) that provides automated scoring and interpretation of the outcome questionnaires. The service will help to monitor your improvement.

Please be assured that your personal information is kept strictly confidential. The questionnaires remain anonymous, identified only by an ID number that is assigned to me. The only information which is disclosed is an ID number, the questionnaire, your age, gender, diagnosis, general health status, and whether you have received mental health treatment previously. The outcomes measurement service center and qualified academic researchers may use the data to investigate ways to improve treatment outcomes. These research professionals do not have access to any information that could be used to personally identify you as an individual receiving treatment, nor do they have any access to your confidential medical records.

You are free to decline to complete the questionnaires. Refusal to complete the questionnaires will not affect your treatment or insurance coverage in any way.

FEE AGREEMENT

I agree to pay the following fees:
• Intake/Evaluation session (1 hour) $150
• Individual/couple or family session (45-50 minutes) $100/$110
• Telephone call or consultation exceeding 5 minutes $100/hr prorated

I understand that payment of my fee or co-payment is due and payable at the time of each counseling session unless otherwise arranged. I agree to pay a $40 fee for cancellations made without 24 hour notice or missed appointments.

I have read this Therapy Policies and Informed Consent Statement and understand that regardless of any insurance coverage I have, I am responsible for payment of my account. I agree that in the event costs and fees are incurred in the collections of my account, I will pay such costs and fees.

RELEASE OF INFORMATION

I have read the Therapy Policies and Informed Consent Statement, including the Fee Agreement, and understand my financial responsibility. I authorize the release of my/our clinical record information to my/our insurance company for the purpose of billing, authorization of treatment, utilization review, and quality assurance review.

If you have any questions concerning the above policies please discuss them with me.

______________________________________________________  ______________________
Signature                                                                 Date

______________________________________________________  ______________________
Signature of Parent, Guardian or Legal Representative Date