**INFORMED CONSENT & AGREEMENT FOR PSYCHOTHERAPY SERVICES**

**Introduction:**

This document is intended to provide important information to you regarding your treatment. Please read the entire document carefully and be sure to ask me any questions that you may have regarding its contents before signing it. You may have questions about me, my qualifications, therapy, or anything not addressed here. It is your right to have a complete explanation for any questions you may have, now or in the future. Please feel free to ask questions or share any concerns that may arise. Although I know this may be uncomfortable at times, your openness and honesty will allow me to better serve you.

**Risks and Benefits of Therapy:**

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings such as anxiety, guilt, sadness, anger, frustration, loneliness, helplessness, etc. because in the process of psychotherapy often requires discussing the unpleasant aspects of your life. There may be times in which I will challenge your perceptions and assumptions, and offer different perspectives. The issues presented by you may result in unintended outcomes, including changes in personal relationships. Sometimes a decision that is positive for one family member is viewed quite differently by another. You should be aware that any decision on the status of your personal relationships is your sole responsibility. However, participating in therapy may also result in a number of benefits to you, including, but not limited to, reduced stress and anxiety, a decrease in negative thoughts and self-sabotaging behaviors, improved interpersonal relationships, increased comfort in social, work, and family settings, increased capacity for intimacy, and increased self-confidence. Such benefits may require a substantial effort on your part, including an active participation in the therapeutic process, honesty, and a willingness to change feelings, thoughts and behaviors.

During the therapeutic process, some people find that they feel worse before they feel better. This is generally a normal course of events. Personal growth and change may be easy and swift at times, but may also be slow and frustrating as well. Due to the varying nature and severity of problems and the individuality of each patient, I am unable to predict the length of your therapy or to guarantee a specific outcome or result. Nor is there a guarantee that therapy will yield any or all of the benefits listed above. My hope is that you will always be willing to discuss with me any concerns you may have regarding your progress in therapy.

**Discussion of Treatment Plan:**

I believe that therapists and patients are partners in the therapeutic process. It is my intention to provide services that will assist you in reaching your goals within a reasonable period of time after the initiation of treatment. At Salem Counseling Place I take a holistic approach to therapy and will work with you in understanding the problem, treatment plan, and therapeutic objectives in order for you to reach your goals.

**Termination of Therapy:**

The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress you achieve. It is a good idea for us to collaborate together about your termination of treatment. I will discuss a plan for termination with you as you approach the completion of your treatment goals. You may discontinue therapy at any time. If you or I determine that you are not benefiting from treatment, either of us may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

**Professional Consultation:**

Professional consultation is an important component of a healthy psychotherapy practice. As such, I regularly participate in clinical, ethical, and legal consultation with appropriate professionals. During such consultations, I will not reveal any personally identifying information regarding you or your situation.

**Collaboration with Other Professionals:**

In order to provide quality services, I at times need to collaborate with other professionals, such as your physician, psychiatrist, past therapists, and/or other mental health professionals. If we decide together that this would be helpful, you will be asked to complete a release of information authorizing these exchanges.

**Records and Record Keeping:**

I may take notes during session, and will also produce other notes and records regarding your treatment. These notes constitute my clinical and business records, which by law, I am required to maintain. Such records are the sole property of the therapist. Should you request a copy of my records, such a request must be made in writing. I reserve the right, under Oregon law, to provide you with a treatment summary in lieu of actual records. I also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. I typically maintain records for seven years following termination of therapy. After seven years, your records will be destroyed in a manner that preserves your confidentiality.

**Confidentiality:**

The information disclosed by you is generally confidential and will not be released to any third party without written authorization from you, except where required or permitted by law. Exceptions to confidentiality

1. When there is risk of imminent danger to yourself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
2. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.
3. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

If you participate in marital or family therapy, I will not disclose confidential information about your treatment unless all person(s) who participated in the treatment with you provide their written authorization to release such information. However, it is important that you know that I utilize a “no secrets” policy when conducting family or marital/couples therapy. This means that I do not keep secret information gathered in individual conversations (whether on the phone or in an individual session) if the information revealed in some way violates the integrity of the couples/family therapy (such as revealing an affair, substance problem, or intent to leave the relationship). Such information will need to be revealed to the other partner for therapy to effectively continue. Please feel free to ask me about my “no secrets” policy and how it may apply to you.

**Patient Litigation:**

I will not voluntarily participate in any litigation or custody dispute in which you and another individual, or entity, are parties. I have a policy of not communicating with patients’ attorneys and will generally not write or sign letters, reports, declarations, or affidavits to be used in any patient’s legal matter. I will generally not provide records or testimony unless compelled to do so. Should I be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving you, you (not your insurance company) agree to reimburse me for any time spent for preparation, travel, or other time in which I have made myself available for such an appearance at my customary hourly rate for such services of $325.

**Email and Phone/Text Messaging Communication:**

Some patients prefer to communicate about appointment times or other administrative issues via email or phone. Although information stored on my computer is encrypted, email or text messages transmitted through regular services are not encrypted. This means that a third party may be able to access information in an email or through text messaging and read it, since it is transmitted over the Internet or phone. In addition, once the email or text messages are received by you, someone may be able to access your email account or cell phone and read it. This may include your employer if you use a work-related email address.

**Therapist Availability / Emergencies:**

You may leave a message for me at any time on my confidential voicemail at 503-510-3127. If you wish me to return your call, please be sure to leave your name and phone number(s), along with a brief message concerning the nature of your call. Non-urgent phone calls are generally returned within 24 hours during normal workdays (Monday through Friday).

#### Please understand that as a small practice I do not provide continuous 24-hour crisis services. In the event of a medical emergency or an emergency involving a threat to your safety or the safety of others, please call 911 to request emergency assistance, or go to the nearest emergency room, or contact other resources as listed:

#### Psychiatric Crisis Center - 503-585-4949; National Child Abuse Hotline - 1-800-4-A-Child; National Domestic Violence Hotline – 1-800-799-SAFE OR TTY 1-800-787-3224; National Sexual Assault Hotline (RAINN) - 1-800-656-HOPE; National Suicide Prevention Lifeline - 1-800-273-TALK OR TTY 1-800-799-4TTY; and Teen Line Online - [www.teenlineonline.org](http://www.teenlineonline.org), 1-800-852-5336.

**RATES AND INSURANCE**:

#### Therapy Fees:

* $200 Initial appointment 60minutes
* $175 Therapy session 60 minutes
* $145 Therapy session 45 minutes
* Uninsured or self-pay good faith estimate for one month weekly sessions $480-$700
* Please inquire if you need additional help in regards to payment.

**Forms of Payment:**

Cash, Checks, PayPal, or Credit Cards are accepted, and payment is due at time of service. Any returned checks are subject to an additional $35 bank fee, which I reserve the right to change as bank fees change.

**Insurance:**

Salem Counseling Place is contracted with some insurance agencies except Medicare. Clients are expected to pay at the time of service. Clients can be supplied with appropriate receipts and coding (coding will come from diagnoses out of the DSM – 5) so that you may seek reimbursement from your insurance company. Please inform me if you wish to utilize health insurance to pay for services. Although I am happy to assist your efforts to seek insurance reimbursement, I am unable to guarantee whether your insurance will provide payment for the services provided to you, the amount of reimbursement, and the amount of any co-payments or deductible depends on the requirements of your specific insurance plan. You should be aware that insurance plans generally limit coverage to certain diagnosable mental conditions, which then become part of your medical record. While insurance companies claim to keep such information confidential I have no control over what they do with your information once they have it. You are responsible for obtaining prior authorization for treatment from your insurance carrier. Please discuss any questions or concerns that you may have about this with me. If for some reason you find that you are unable to continue paying for your therapy, please inform me. I will help you to consider any other options that may be available to you.

**Cancellation Policy:**

If you do not show up for your scheduled therapy appointment, and you have not notified me at least 24 hours in advance, you will be required to pay $45.00 for the missed appointment. Exceptions will be made for illness or emergencies.

if an appointment can be rescheduled within the same week, you will not be charged for the missed appointment.

**Delinquent Accounts:**

You understand that you are responsible for all charges incurred and that services must be paid in full at the time of each visit, unless other arrangements have been made in advance. Should your account become delinquent, you agree to pay a late fee of $10 per month, and if it becomes necessary for the account to be referred for collection action, you agree to pay the actual balance due plus any collection expenses of 30-50% of any balances owing, and any attorney’s fees

**After reading this Informed Consent: Signing acknowledgements form is accepting you have read, understood, asked any questions that you may have regarding this document, and have been offered a copy of this form for your own records. The *ACKNOWLEGEMENTS PAGE is to be printed and brought to your first appointment.***