INFORMED CONSENT FOR TREATMENT

You have rights and responsibilities as a client seeking to engage in counseling with me. Furthermore, the federal Health Insurance Privacy and Accountability Act (HIPAA) entitles you to certain confidentiality. If you would like to review a more detailed explanation of my HIPAA practices than what is provided here, please ask for a copy of my Notice of Privacy Practices or view the document on my website at www.laurendahl.org.

Rights

- ***You have the right to be informed of the terms under which treatment will be provided.*** *You are, however, responsible for asking any questions regarding the policies below.*
- ***You have a right to know my qualifications and training.***
- ***You have the right to refuse or terminate treatment at any time and for any reason.***
- ***You have the right to know that sometimes you can feel worse at the beginning of treatment instead of better.*** *This is simply a result of opening up old wounds and discussing painful topics that you may have been avoiding, and it should ease over time, if it happens at all.*
- ***You have the right to confidentiality as specified by state and federal law.*** *This means that anything that you tell me and/or that I write down in your file will not be repeated or released to anyone else without your written permission. You, of course, may discuss your treatment with anyone you choose, including another therapist.*
- *Should you wish to use your insurance benefits, it is necessary for you to sign a Consent to Bill Insurance form in order for me to bill your insurer or to request additional sessions as needed. While billing information is generally limited to your diagnosis, date of service, and type of session (individual, family, etc), insurance companies can request additional information when authorizing services. By signing the consent, you agree that I can provide your insurer with the necessary details regarding your treatment to obtain authorization and/or payment.*
- *There are certain situations in which Oregon State Law requires that confidentiality be broken, even if it is against your wishes. These include:*
  - ***Child or elder abuse or neglect****: I am required by law to report any <u>suspicion</u> of abuse to the Department of Health and Human Services. This means that any time that I hear of physical violence towards or sexual contact with a child or elderly person or see marks indicating such an incident has occurred, I have no choice but to report it. Oregon law also considers domestic violence or substance abuse in a child's presence to be abuse.*
  - ***Violence****: If I have reason to believe that you intend to harm someone else, I am required by law to attempt to notify that person.*
  - ***Suicide****: If I believe that you are in danger of killing yourself, I will break confidentiality to ensure your safety.*
  - ***Consultation****: At times, it may be helpful for me to consult with colleagues regarding your best treatment options. If this is necessary, consultation will be done without the use of your name or identifying information unless you have given written permission.*
  - ***If you are under the age of 18****, I cannot prevent your parents from seeing your record if they insist upon doing so. I would strongly discourage that they do this and would provide any summary of your treatment only after discussing it with you first.*
  - *Any other breaches of confidentiality will be done only with your signed release of information and will be handled with great respect for your privacy.*
- ***You have the right to see and/or receive a copy of your clinical record at any time.*** *You may be charged a fee for the cost of copying records.*
  - *If there is some reason that seeing your record would be harmful to you or someone else, I may —with an explanation—deny your request to see your record.*
  - *Should you elect to review your record, it is strongly recommended that you do this with me so that terms and abbreviations can be explained.*
  - *Should you find any errors in your record, you have the right to have them corrected.*

• *If you believe that I have violated your right to access your record or if you believe that I have provided your information to someone without complying with U.S. laws, you may file a complaint with the Office of Civil Rights at 800-788-4989. I will not take any action against you for filing a complaint.*

<u>Responsibilities</u>

• ***Once we schedule an appointment, you will be responsible for paying for it unless you provide <u>24 hours' advance notice</u> of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). This includes no-shows. You will be charged $65. ____Initials***

• ***You are responsible for paying your session fee or copay/deductible at the beginning of our sessions****. A standard session is 50-60 minutes in length unless otherwise arranged in advance.*

• ***You are responsible for knowing your insurance benefit limitations.*** *You should contact your insurer directly to determine whether your treatment requires preauthorization, if you have a deductible to meet, and the amount of your copay.*

• *If your insurer requires preauthorization of the first session and you do not obtain it, you are responsible for the full cost of that session.*

• *You are not responsible for the cost of sessions for which I am required to obtain the preauthorization (this usually relates to ongoing treatment rather than the initial session).*

• *You are responsible for notifying me of any changes in your insurance coverage.*

• *You are responsible for paging me (503-202-0358) or calling Washington County Crisis (503-291-9111) if you find yourself in an emergency mental health situation. You are responsible for keeping me informed regarding changes in your contact information.*

• *You are responsible for letting me know if you are dissatisfied with your treatment in any way. I cannot address the problem if I do not know that there is one.*

• *You are responsible for working at least as hard as I am to address the concerns that brought you or your child to therapy. You will have to work on the things we talk about both during sessions and at home if you want to change.*

<u>Communication Policies</u>

• ***Email:*** *If you choose to communicate with me via email, you should understand that confidentiality cannot be guaranteed due to the nature of Internet security as well as the possibility that others in your household or place of employment could access your emails. I do use up-to-date Internet security systems and will make every effort to protect your information from my end.*

• *Please be aware that all email messages are retained in the logs of your and my Internet service providers (ISP). While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator of the ISP.*

• *Any emails I receive from you and any responses that I send to you become a part of your official clinical record.*

• *<u>Do not use email to contact me in an emergency</u> as I cannot guarantee that I will receive or respond to such communication immediately.*

• ***Social Media:*** *I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.). Doing so can compromise your confidentiality and both of our privacy.*

• ***Texting:*** *My office phone cannot accept text messages and I do not reply by text message. Again, this can compromise your confidentiality.*

I/We, _____have read the above rights and responsibilities, have had the opportunity to review the Notice of Privacy Practices, and have had any questions answered. I/We understand and agree to these policies.

_____ _____ _____

Client Signature Client Signature Date