Thriving Families LLC
25 NW Park Place
Bend, OR 97701
(541) 668-6891

INFORMED CONSENT AGREEMENT

1. Treatment Agreement

Welcome to my practice. This Informed Consent Agreement ("Agreement") contains important information about my professional services and business policies. It is also intended to inform you of state and federal laws and your rights. We can discuss any questions you have before you sign this document or at any time in the future. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it or if you have not satisfied any financial obligations you have incurred.

2. Description of Services

a. Thriving Families Practice. Thriving Families is a private practice that offers therapy for children, teens, and families. I do individual, family, and parenting work as appropriate. Psychotherapy has both benefits and risks. I try to limit these risks and help you be aware of them. Psychotherapy has been shown to have benefits for individuals who undertake it, but there are no guarantees about what will happen. It is important to know that as problems are faced sometimes they get worse. Therapy may result in strong emotional feelings that may be uncomfortable. Therapy may be stopped at any time, but I would like the opportunity to discuss it with you before you make a final decision. It is customary to schedule a final session to discuss end of treatment issues and possible referrals. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

b. Treatment Overview. Typically, the first 2-4 sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions at any time, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

3. Office Policies

a**. Appointments and Cancellations.** Appointments will ordinarily be 50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with 48 hours notice (2 business days). If **you miss a session without canceling, or cancel with less than 48 hour notice (2 business days), my policy is to collect the amount of the full session.** If there is an emergency or illness, please contact me so we can discuss it. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still need to end on time and you will still be charged the full cost of the session. If I am running late, I will do my best to give you a full session. If I am unable to do so, then a prorated amount of my hourly rate of $115 will be charged.

_____ I understand that sessions must be cancelled 2 business days (48 hours) in advance or there will be a charge of $115. (Please initial.)

b. **Phone Access and Emergency Coverage.** Telephone calls are reserved for scheduling matters. Any consultation calls are billed at the hourly rate of $115. **I do not provide 24-hour coverage. If there is a crisis or an emergency, please leave me a voicemail at (541) 668-6991 and then go to the nearest emergency room or call the Deschutes County Crisis Line at (800) 875-7364.** I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

c. Email and Texting. If you elect to communicate with me by email or text, or decide to receive appointment reminders by email or text, please be aware that email and text messages are not completely confidential. Please note that anything you send me electronically becomes a part of your legal record, even if I do not place it in your clinical record. Please note that I only use email and text to communicate about appointments. Discussions therapeutic in nature will be handled on the phone or in session.

I may be contacted by: _____ email, _____ text, and/or _____ phone. (Please initial.)

I would like appointment reminders by _____ email, _____ text, and/or _____ phone. (Please initial.)

d. Shared Office Space. Although I share this office space and some office equipment with other professionals, we are not in business together as partners, employers, or employees. We are all independent professionals.

e. Touch. When appropriate and with your approval, I may use touch in our work together. Touch may include handshakes, high five's, pats on the back, or brief hugs for encouragement and support. Touch may be used during a specific intervention such as EMDR, where I may tap your knees or hands. You are free to refuse touch at any time. Certain psychological histories may preclude the use of touch such as past sexual abuse or certain traumas. However, with consent, touch may be used purposefully and with clinical judgment to teach appropriate and healthy boundaries.

____ I consent to the use of touch in therapy and I will make concerns known to my therapist as they arise. I may refuse touch or revoke this consent at any time. (Please initial if you agree.)

4. Health insurance

I am not on any insurance panels and therefore I am not in-network for any insurance companies. Also, because I am a registered LPC intern, sessions can not be claimed for out of network benefits.

5. Confidentiality

Treatment is generally confidential except for the exceptions detailed below. You may direct me to share information with whomever you choose by completing a Release of Information form and you may change your mind and revoke that permission at any time. You are also protected under the provisions of the Federal Health Insurance Portability and

Accountability Act (HIPPA). This law ensures the confidentiality of all electronic transmission of information about you.

While your treatment is generally confidential, there are exceptions such as:

(1) **Suspected Abuse.** I may report suspected abuse including child, elder, animal, and mentally ill/ developmentally disabled.
(2) **Threat to Harm Yourself or Others.** If I believe you are a serious threat to yourself or others, I will take the appropriate action to protect you or others.
(3) **Medical Emergency.** I may disclose information that would facilitate treatment of a medical emergency.
(4) **Court Proceeding /Subpoena.** If you become involved in a lawsuit, or if a court orders your records to be released, I may have to release your records.
(5) **Legal Defense.** If a client files a complaint or lawsuit against me, I may disclose relevant information in order to defend myself.
(6) **Government Health Oversight.** If the government agency or the Oregon Board of Licensed Professional Counselors and Therapists requests information for health oversight activities, I may be required to give it to them.
(7) **Worker's Compensation Claim.** If you file a Worker's Compensation claim, this constitutes authorization for me to release your relevant mental health records to involved parties and officials.

6. Professional Records.

I am required to keep appropriate records of the therapeutic services that I provide. Your Clinical Record may include information about the following: your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others (for which I will provide you with an accurate and representative summary of your Record if you request it), you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon request. Records are kept for 7 years after the end of treatment.

7. Minors and Parents

a. Treatment Records. The law may allow parents to examine treatment records of minors. Because privacy in psychotherapy is often crucial to successful progress, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records during treatment. If the parents agree, I will provide parents only general information about the attendance and progress of their child's treatment. Any additional communication will require the child's authorization, unless I think the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern immediately. If a child is a minor, both custodial and non-custodial parents have access to treatment records.

b. Consigner. I require a cosigner for payment if a young adult is not yet financially stable. The cosigner is responsible for all fees incurred, even if the patient is over 18 years of age.

c. Treatment of minors 14-17 years old. In the state of Oregon, a minor of 14 years age or older may consent to treatment without their parent's permission or knowledge. In this situation, it is my policy and the law to include parents prior to the end of treatment unless there is a clear indication to the contrary or the parents refuse. Both of these circumstances will be documented in the clinical record. Please note that though a minor can consent to treatment, their parents may still request and have access to the records.

d. Evidence of Custody and Guardianship. I require a copy of the most recent legal documentation showing the custody or guardianship arrangement for the minor if both parents no longer have full legal and physical custody or if there is a separation or divorce of the parents.

e. Payment Responsibility for Separated or Divorced Parents. The parent consenting child to treatment will be responsible for all fees incurred in treatment, unless there is a session alone with the other parent then that parent is financially responsible for that particular session.

8. Other Rights

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe, and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, socioeconomic status, marital status, or national origin. You have the right to ask questions about any aspects of therapy and about my specific training and experience.

9. Acknowledgement and Consent to Treatment

_____ I have read and been offered a copy of the Notice of Privacy Practices. (Please initial.)

_____ I have read and received a copy of the Professional Disclosure Statement. (Please initial.)

By signing below, I acknowledge that I have read and fully understand the information contained in this Agreement, the Notice of Privacy Practices, and the Professional Disclosure Statement and agree to all of their terms.

____
Client's Printed Name

___________________________ ________
Client's Signature Date

____
Parent's Name if Client is a Minor

______________________________ __________
Parent's Signature if Client is a Minor Date

______________________________ __________
Therapist Signature Date