AGREEMENT AND INFORMED CONSENT FOR TREATMENT

Treatment Agreement

Welcome. I appreciate the opportunity to serve you as a counselor. This document (the AGREEMENT) contains important information about my professional services and business policies, as well as summary information about the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA is the federal law that provides for privacy protections and patient rights regarding your Protected Health Information (PHI). HIPAA regulations require that I provide you with a NOTICE OF PRIVACY PRACTICES (the NOTICE) regarding the use and disclosure of your PHI. The law also requires that I obtain your signature acknowledging that I have provided you with this information at the start of treatment. Although these documents are long and sometimes complex, it is important that you read them carefully before signing. You will also receive copies of this information for your records. If you have any questions or concerns about this information, please let me know so we can address them.

When you sign the AGREEMENT, it represents a formal agreement between us. You may revoke this agreement in writing at any time, and that revocation will be binding unless (1) I have already taken action in reliance upon it, (2) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or (3) you have not satisfied financial obligations incurred by you. Please keep a copy of this office policy statement for your records. A second copy, signed and dated, will be kept in your file. It is important you read the entire statement carefully and ask any questions you may have before signing.

General Standards

I work from a Cognitive-Behavioral orientation using a DBT-informed emphasis. Therapeutic sessions frequently involve the use of behavioral analyses, which are designed to identify prompting events (or antecedents), vulnerability factors, problematic thoughts and emotions, and short-term reinforcers for problematic behaviors and patterns. Interventions at these various key points in the behavioral analysis can then be implemented to change the problematic behavior. In short, I find that changes in behavior can lead to changes in thoughts and beliefs and, conversely, that changing thoughts and beliefs can lead to behavior change. I also recognize that problems are transactional in nature and changes often need to take place within one's environment in order to improve functioning. In addition to my Cognitive-Behavioral orientation, I utilize the Stages of Change Model, which emphasizes accurate assessment of one's readiness to change, and implements appropriate strategies and interventions based on one's level of readiness to change. By integrating parameters of this model with my existing CBT and DBT emphases, I find that significant movement can be made and insights can be gained, even when clients are not completely committed to making changes.

Our first few sessions will serve as an initial evaluation of your concerns, history, goals, and needs. By the end of this evaluation, I will provide you with my impressions of how our work might proceed and with a potential treatment plan. You should consider this information along with your own impressions and your comfort level with me, so that we can decide together whether I am the best person to provide services to meet your treatment goals. Therapy can be a big commitment, so you should select a therapist carefully.

If we agree to enter into a therapy relationship, I generally recommend weekly 45- or 55-minute sessions in the early stages of your treatment in order to build rapport, establish consistency within the therapy process, and to decrease the initial discomforts and anxieties that often (though not always) accompany the early stages of therapy. This recommendation is highly flexible, however, and other arrangements can be made. Treatment duration is highly variable, depending on your presenting concerns, the treatment plan, and other factors. During our work together, we

will periodically review your goals and progress. I may request your written authorization and permission to consult with other treatment providers that you currently work with, or have worked with in the past. I may also request that you have a medical or psychiatric evaluation to aid in treatment. For potential clients that are experiencing substance-related issues, I complete a full evaluation based on placement criteria as defined by the American Society of Addiction Medicine (ASAM-PPC). This evaluation provides clear rationale for the levels of service I may recommend to clients. If we agree to enter into a therapy relationship and you are experiencing a substance use issue, it is important that you understand that this evaluation may be ongoing, and that there are occasions in which I may make recommendations to higher levels of care (such as to detox, intensive outpatient, residential or inpatient services). You have the right to be fully informed of this process, and to address any question or concerns you may have. In addition, clients presenting with substance use issues may, on occasion, be referred to local facilities for urinalysis testing. This recommendation is made on a case-by-case basis, and the cost of urinalysis testing is the responsibility of the client.

It is important for you to know that psychotherapy involves risks and benefits. Occasionally individuals go through periods in therapy that may result in increased emotional discomfort or worsening of their symptoms. These periods should subside as the work progresses. Psychotherapy has also been shown to have benefits for those who attend and can improve your ability to regulate your emotions, behaviors and thoughts and result in improved relationships and life circumstances. It is important for you to know that, although there is evidence that shows the effectiveness of Cognitive-Behavioral and Dialectical Behavioral Therapy, it is not presented here as a guarantee of the efficacy of this treatment. You always retain the right to request changes in treatment or to refuse treatment. I encourage you to discuss any personal doubts, concerns, or discomforts regarding your treatment, at any time.

Confidentiality

I am a Licensed Professional Counselor (LPC) through the Oregon Board of Licensed Professional Counselors and Therapists, a Nationally Certified Counselor (NCC) through the National Board of Certified Counselors (NBCC), and a Certified Alcohol and Drug Counselor (CADC-I) through the Addiction Counselor Certification Board of Oregon (ACCBO). I adhere to the ethical principles defined through the American Counseling Association, the NBCC, and ACCBO. These principles establish guidelines that govern privilege and confidentiality. I maintain confidentiality in creating, storing, accessing, transferring, and disposing of records in any medium. Your Clinical Record includes your reasons for seeking therapy, how your life is being impacted, your diagnosis, the goals we have set for treatment, your progress toward those goals, your medical, social and treatment history, any past treatment records I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone per your request. Your billing records include your contact information and billing statements. All records and notes are kept locked or password protected, and all records are retained for a minimum of seven years as required by law. In the event of your death, the privilege to access your record passes to your estate. In the event of my own incapacitation, withdrawal, or death, another licensed professional will assume responsibility for my records. The name of my designated clinician, under the above circumstances, can be obtained by contacting the Oregon Board of Licensed Professional Counselors and Therapists. By submitting a written request, you may examine and/or receive a copy of your Clinical Record, except in circumstances where disclosure would be injurious to you or would constitute an immediate and grave detriment to your treatment. In such circumstances, I may provide you with an accurate and representative summary of your Clinical Record, if requested. Professional records can be very confusing and/or upsetting to an untrained reader. For this reason, I recommend you review them in my presence or with another mental health professional. In most circumstances, I will charge a copying/printing fee of 25¢ per page. If you wish to review your Clinical Record, please address your request to me, so we can discuss the best way to make this happen.

In general, the law protects the privacy of all communications between a client and a counselor. I will not disclose anything you tell me, not even the fact that you are a client, without your written permission via a signed release of information form. There are a few exceptions to these standards:

1. It is legally required of me to act so as to prevent physical harm to others or to society when there is "clear and imminent" danger of that happening.

2. I am ethically bound to act to protect you or others from harm. This may include, but is not limited to, contacting law enforcement if I determine that you may be driving under the influence.

3. I am ethically bound to report cases of ongoing child, elder, and disabled abuse.

4. I may have to release clinical information regarding your treatment to insurance carriers as required for payment or review of your claim. Your written consent for me to send claims to your insurance implies permission to send clinical information to your insurance.

5. I may have to release your records when ordered to do so by court subpoena or judge order. However, I will discuss the details of privilege with you beforehand and request a written release from you if I judge this to be in your best interest. In some cases involving child custody and those in which your emotional condition is an important issue, a judge may order the release of your information if he/she determines that the issues demand it.

6. I may also release information about you in my defense if you file a complaint.

7. I may use electronic transmission to send treatment plans, reports or evaluations to your insurance company, specific agencies or other providers.

8. Email and text message correspondence is not guaranteed to be confidential.

9. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to protect the identity of my clients. The consultant is also legally bound to maintain confidentiality.

10. I may be legally required to release confidential information as determined under the USA Patriot Act. Under this Act, I may be ordered to not inform you of such disclosures.

Family Therapy Sessions for an Individual

During the course of assessment and treatment, we may decide to schedule a family therapy session (including other family members such as a spouse/partner) or determine if family therapy sessions are the appropriate mode of therapeutic treatment for your goals. At that time, participating family members may be asked to sign a Collateral Agreement Form indicating that, although they may be present and engaged in sessions, they are not my clients. Accordingly, the tenets of confidentiality and legal privilege will not extend to them. You will remain my client and you will retain the right to access the therapy records and/or release them to a third party, with exceptions as allowed or required by law. The purpose of family sessions will be to address your individual concerns and will be discontinued if they do not appear to be beneficial towards reaching your treatment goals.

Legal Proceedings

It is important for you to know that I am not a forensic psychologist or a child custody evaluator. I will not be a party to legal proceedings against current or former clients. My goal is to support my clients to achieve therapy goals, not to address legal issues that require an adversarial approach. Clients entering treatment are agreeing to not involve me

in legal/court proceedings or attempt to obtain records of treatment for legal/court proceedings when therapy has been unsuccessful at resolving disputes. This prevents the misuse of your treatment for legal objectives.

Appointments

Individual sessions are arranged by appointment only and are 45-55 minutes in length. If I am late, I will make up the missed time or prorate your bill. If you are late, you will lose that portion of time from your session and will be charged for the appointment. Cancellation of sessions should be avoided. If you need to cancel an individual therapy appointment, you will not be charged for the appointment if you notify me 24 hours in advance of the scheduled appointment. No show/no call or late cancelled sessions will be charged to you at $80. Fees for missed sessions are not reimbursable by insurance companies. Cancellations can be phoned into the office any time. I do make exceptions for illnesses, inclement weather, or other unforeseen circumstances, so long as these matters are communicated to me as early as possible.

Telephone Calls, Email, and Emergencies

I am generally available by phone, and I check my voice mail several times a day during business hours. Phone calls are returned as soon as possible, usually within 24 hours, except on weekends and holidays. I do not answer the phone when I am with clients, and my availability at other times cannot be guaranteed. You may leave a confidential voice mail for me at any time. If you are difficult to reach, please inform me of some times when you will be available. Because voice mail technology is not error proof, if you have not heard back from me by the end of the next day, please feel free to call again since it is likely that I did not receive your original message. Please be sure to state if you are calling about an urgent matter. If you are in crisis and need to speak to someone immediately, please call the Multnomah County Crisis Line at 503.988.4888, or the crisis line for your county. In the case of a life-threatening emergency, call 911 or go to the nearest hospital emergency room.

I use my email address primarily to send documents to you when necessary. All other contact should be through phone and voice mail. This is primarily due to the unreliable and un-secure nature of email. Please limit e-mail or text correspondence to appointment scheduling or billing questions/concerns. If you choose, at your own risk, to use e-mail to share personal or clinical information, please note that these will become part of your clinical record. I do not regularly check my email, so it is not a good way to reach me in an emergency.

Safety Policy

Staff and client safety are of utmost importance. As such, any act of aggression to self, others, or property while on site may be grounds for compensation for damages, legal action and/or immediate termination of services.

Fees

My fees for therapeutic services are the following:

$200 per Intake session

$160 per Individual session (45 or 55 minutes)

$175 per Family session

$50 per Group session.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

I accept all major forms of payment (credit/debit cards, checks, and cash). A 5% discount on out-of-pocket expenses applies for check or cash payments made at the time of the session. There is a $25.00 processing fee on returned checks. Payment for the returned check amount plus the processing fee must be paid before your next scheduled appointment.

You are agreeing to pay for all services provided prior to the discontinuation of treatment. You can discontinue treatment at any time by phone or in person. If your account is not paid within 90 days, I have the option of using legal means to secure payment. This may involve the use of a collection agency or small claims court. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and amount due.

Insurance

While I will do my best to assist you with your insurance benefit, it is important for you to call and find out exactly what mental health services your insurance policy covers and if you are required to obtain preauthorization for services. You should carefully read the section in your insurance policy and call your insurance company if you have questions. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis and some require treatment plans, summaries or a copy of the entire record. Though insurance companies claim to maintain confidentiality, I do not have control over your information once it is in their hands.

The contract for professional services and payment is with you. If you choose to use your health insurance coverage, I will submit claims on your behalf. It is your responsibility to notify me of changes to your insurance, and whether you want claims submitted to secondary insurance plans (Insurance Information Forms must be completed for all insurance plans). You are asked to pay your co-payment or non-covered amounts at the time of service. Clients using out-of-network benefits will be charged the "member responsibility" amount as indicated on their Explanation of Benefits statements. This may also be referred to as "patient responsibility" or "patient liability." Mental health reimbursement policies differ dramatically from one third-party contract to another. It is often difficult to predict the services and fees different plans will cover. For this reason, it is important to discuss these issues in your early sessions or when there is any change in your insurance to avoid confusion and problems that could interfere with our work together. It is important to note that even when I have filed an insurance claim on your behalf, if after 90 days I have not been paid by your insurance company, you will be required to pay the past due balance. While I do my best to collect on past due insurance claims, I cannot accept responsibility for following up on past due or disputed claims. Regardless of the insurance company's handling of the claim, you are responsible for all fees.

CONSENT TO TREATMENT

I have read and understand this Agreement and Informed Consent for Treatment in its entirety. Fee arrangements and terms of confidentiality have been clearly made. My signature below indicates that I agree to all terms herein, and I have received a copy of this Agreement upon request, and that I wish to enter treatment on these conditions. As part of my agreement to enter psychotherapeutic treatment with Heidi Jolson, LPC, NCC, CADC-I, I acknowledge the following understandings:

1. I understand that although there is empirical evidence for the effectiveness of psychotherapy, this evidence is not presented as a guarantee either direct or implicit of the effectiveness of this treatment.

2. I understand each individual must independently evaluate and use his or her own judgment in choosing among treatments and therapists available.

3. I understand there are other therapist and treatments available to me. I therefore maintain the right to seek second opinions and other therapeutic options available for addressing my issues and concerns.

Client signature:	Printed name:	Date:
Signature of legal guardian (if applicable):	Printed name:	Date:

I, the therapist, have discussed the issues above with the client and provided a copy for their records (if requested) .

_____ _____ Provider

Signature Date

By signing this form, I agree that I have read been provided with a copy of the Notice of Privacy Practices for Protected Health Information (upon request) for the office and practice of Heidi Jolson, LLC.

Client signature:	Printed name:	Date:
Signature of legal guardian (if applicable:	Printed name:	Date:

FINANCIAL AGREEMENT

Insurance Authorization: Heidi Jolson, LPC, NCC, CADC-I has my permission to bill my insurance company(s) and to provide necessary information for the purposes of obtaining authorization for services, benefit information, and payment. I agree that payments or copays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. I understand that no show or late cancelled sessions (less than 24 hours notice) will be charged to me at full fee and cannot be charged to my insurance company and that there is a returned check processing fee of $25.00.

Client signature:	**Date:**

Out-of-Pocket Payment Agreement:

I, _____, am choosing to make out-of-pocket payments for the clinical services I receive with Heidi Jolson, LPC, NCC, CADC-I. I am doing this for the following reason:

o I do not presently have insurance with mental health benefits.

o I have mental health benefits with _____ (Insurance Company), however:

o I have exhausted my current outpatient mental health benefits

o I am choosing not to use my insurance benefits at the present time.

o I wish to be treated by Heidi Jolson, LPC, NCC, CADC-I, who is not a paneled member of my insurance network. However, I authorize Heidi Jolson, LPC, NCC, CADC-I to submit claims to my insurance if I have out-of-network benefits available. If claims to out-of-network benefits are submitted, I understand that some plans will direct me to pay the entire billed amounts in full, and I will be reimbursed directly by my insurance company for approved claims.

o My concerns are not covered by my insurance benefits or are not deemed medically necessary by my insurer.

My fees are as follows: $200 Assessment; $160 Individual Therapy; $175 Family; $50 Group;

This agreement pertains to services beginning _____ (date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is obtained and I consent for Heidi Jolson, LPC, NCC, CADC-I to bill my insurance. I agree to make out-of-pocket payments at the time that services are rendered. These payments can be made with cash, check, or debit/credit card (Visa, MC, Discover, or American Express).

Client signature:	Printed name:	Date**:**
Signature of legal guardian (if applicable:	Printed name	

Client Information Sheet

Name:	Date:	DOB:
Age:	Marital status:	Gender orientation:
Sexual orientation:	Driver's license/state ID#	SSN (optional)
Home address:	Phone number: Work number:	Email:
Can I leave a message: _____yes _____no	Can I identify myself and my profession? _____yes _____no	Can I use your email for verifying appointments and/or sending financial/billing information? _____yes _____no
Employer/job title:	Work address/phone:	Can I leave a message at your place of employment? _____yes _____no
Name of emergency contact:	Relationship:	Phone:
Who referred you to this office?	Reason for referral:	May I contact your referral source to say thank you?
I understand that text messaging is not guaranteed confidential. Knowing this, I give consent to send/receive text messages for the purpose of appointment verification:	Initial here _____ if you would like to send/receive text messages for scheduling or appointment cancellations.	Initial here _____ to indicate your understanding that texts or emails that are clinical in nature will become part of your clinical record.

Insurance Information Sheet (Please make additional copies for additional insurance plans)

Please be prepared to show photo identification and your insurance card. Please have this form available when calling your insurance company to verify benefits, eligibility, deductible, and preauthorization requirements.

Insurance company name:	Primary or Secondary? (please check one) Primary _____ Secondary _____
Policy holder's name:	DOB of Policy Holder
Address:	
City: State:	Zip:
Client's relation to policy holder (check one): _____Self _____Spouse/domestic partner _____ child _____other	
Home phone:	Work Phone:
May I contact the policy holder for this plan to ask questions about the insurance plan, or make clarifications about billing policies? (check one) _____ yes _____no	
Policy Holder's employer:	
Policy Holder's plan name:	
Billing/Claims Address (see insurance card):	
City, State, Zip:	Phone:
Identification #:	Group #:
Co-pay amount: $_____ Or coinsurance percentage: _____% Is this the in-network or out-of-network co-pay (check one)? _____ In-network _____ Out-of-network	
Deductible amount: $_____ Deductible met (check one)? _____yes _____no. If not met, how much remaining? $_____	