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Agreement and Informed Consent to Treatment

Welcome to my practice. This document contains important information about the counseling process and your rights as a client of mine. Please feel free to ask any questions you may have about these policies.

Counseling Services

I am a Licensed Professional Counselor (LPC) with the State of Oregon number C1488 and a Nationally Certified Counselor number 54752. I received my Masters Degree from Western Seminary and have worked in inpatient mental health clinics, drug and alcohol programs and church service since 1987.

Counseling can have benefits as well as risks. Some risks include unpleasant feelings such as guilt, sadness, anger, disappointment and loneliness. Despite those risks and challenges, counseling has been shown to benefit most people. Together we will establish a course of action to meet your goals and minimize the risks of counseling. Sometimes it is important to realize when the “fit” is not right and you may need another counselor. If that is the case, it is important that we discuss that together and seek the best treatment possible. If you ever have questions about my approach to counseling, please ask.

Scheduling

Most sessions are 50 minutes with a few additional minutes to schedule another appointment. Arrangements can be made for longer appointments for an additional fee. This is sometimes helpful when working with couples. Please note that insurance may not cover longer sessions. I make every effort to begin and end on time to respect everyone’s time, including the person who is scheduled after you. If you are late, we will end on time and the fee will be for the normal session time.

Counseling Fees

Payment is appreciated at the beginning of each session.
My fees are:

- My fee for individuals or couples: $115
- Phone calls: $25/15 Minutes
- Late Cancellation or No-Show for appointment: $65

Late Cancellation Fee

If you need to cancel an appointment, please make every effort to do so 24 hours in advance. I realize that life happens and I will not bill you the first time this happens but, anytime after that, I will need to charge for my time. If you do not show for an appointment, **you will be charged $65 and please note that insurance does not cover this fee**. I reserve the right to cancel an appointment within the 24 hour window. However, if I am a no-show for an appointment, your next appointment will be free of charge. I value your time and expect that you value mine.

If you have health insurance

Because I am a Licensed Professional Counselor, many insurance companies will cover some of the cost of counseling. However, I do not bill insurance directly and am not on insurance panels. I am an out of network provider. As such, your insurance may not cover my fees and, if they do, they may reimburse at a lower rate. Typically, you may have to pay $10-$20 more per session to meet with me rather than a preferred provider. If you use your insurance, please note that your insurance contract is between you and your insurance provider. You are responsible for paying the fees we agree upon; not the insurance company.

Confidentiality

Privacy is the foundation of all counseling services and is of the utmost importance to me. In the State of Oregon our discussions are considered “privileged communication” which is protected by State law. Except in the specific circumstances below, or with your permission, I will not share with anyone what we discuss.

Consent to Treatment

Sometimes in the course of treatment, it can be helpful for me to communicate with a provider in your life such as your doctor or psychiatrist. In those cases I will ask you for written permission. Some things, by law, cannot be kept private. In the course of counseling if I discover that you are at significant risk of harming yourself of someone else, I am required by law to take action that may include informing authorities or those at risk. I am also required to report harm or injury to children, the elderly and people with

disabilities. Even in these cases, I will attempt to preserve your confidentiality as best as possible. Please see your notice of privacy rights for more information.
If you are using health insurance to pay for counseling, your insurance company may ask for information about your symptoms, your diagnosis, and my treatment methods. I will let you know if this occurs and what the company requested. Please understand that when using insurance, I have no control over how these records are handled at the insurance company. My policy is to provide only as much information as the insurance company will need to pay your benefits. It is important to note that you must receive a diagnosis for insurance to be billed.

Communication and emergencies

My voicemail is confidential and allows you to reach my office any time day or night and leave a message for me to return. Please note that I am not on-call or typically available outside normal office hours. I check my messages daily and attempt to return calls within 24 hours. **I use email or text only for scheduling appointments**. **I do not make clinical comments over email or text**. **Please note that email or texting communication is not secure or private.** My email is bobdorseywrc@gmail.com and my phone number is 971-678-0501. Please note that I do not keep your contact information stored in my phone so please identify yourself when contacting me.

In case of emergency, you may contact the crisis line in Multnomah County at 503-988-4888, Clackamas County at 503-655-8401 or go to the nearest Emergency Room.

Notice of Privacy Practices

Notice of counselor's policies and Practices to Protect the Privacy of Health Information.

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to individually identifiable health information. PHI includes any identifiable health information received or created by my office or me.
- "Treatment, Payment and Health Care Operations"

Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another counselor.

Payment is when I receive reimbursement for your health care or to determine eligibility of coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within my office, clinic, practice group, etc., such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, clinic, practice group, etc. such as releasing, transferring, or providing access to information about you to other parties.
- "Health Information" is information in any form that relates to any past, present or future health of an individual

II. Use and Disclosure Requiring Authorization

I may use or disclose confidential information (including but not limited to PHI) for purposes of treatment, payment, and healthcare operations when your written informed consent is obtained. I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate written authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and healthcare operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes"* are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosure with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause to believe that a child with whom I have had contact has been abused I may be required to report the abuse. Additionally, if I have reasonable cause to believe that an adult with whom I have had contact has abused a child, I may be required to report the abuse. In any child abuse investigation, I may be compelled to turn over PHI. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my clients and

others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.

- **Mentally Ill or Developmentally Disabled Adults:** If I have reasonable cause to believe that a mentally ill or developmentally disabled adult, who received services from a community program or facility has been abused, I may be required to report the abuse. Additionally, if I have reasonable cause to believe that any person with whom I come in contact has abused a mentally ill or developmentally disabled adult, I may be required to report the abuse. Regardless of whether I am required to disclose PHI or to release documents, I also have an ethical obligation to prevent harm to my clients and others. I will use my professional judgment to determine whether it is appropriate to disclose PHI to prevent harm.
- **Other Abuse:** I may have an ethical obligation to disclose your PHI to prevent harm to you or others.
- **Health Oversight:** The Oregon State Board of Licensed Professional Counselors may subpoena relevant records from me should I be the subject of a complaint.
- J**udicial or Administrative Proceedings:** Your PHI may become subject to disclosure if any of the following occur: If you become involved in a lawsuit, and your mental or emotional condition is an element of your claim, or a court orders your PHI to be released, or orders your mental evaluation.
- **Serious Threat to Health or Safety:** I may disclose confidential information when I judge that disclosure is necessary to protect against a clear and substantial risk of imminent serious harm being inflicted by you on yourself or another person. I must limit disclosure of the otherwise confidential information to only those persons and only that content which would be consistent with the standards of the profession in addressing such problems.
- **Worker's Compensation:** 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. This would include a past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

IV. Client's Rights and Counselor's Duties

Client's Rights:

- *Right to Request Restrictions:* You have the right to request restrictions on certain uses and disclosures of Protected Health Information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:* You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, you may not want a family member to know that you are seeing me. Upon your request, I will send bills to another address).

- *Right to Inspect and Copy:* You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend:* You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to Accounting:* You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy:* You have the right to obtain a paper copy of the Notice from me upon request, even if you have agreed to receive the Notice electronically.

Counselor's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policy and practices described in this Notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post a summary of the current notice in the office with its effective date clearly shown at the top. You are entitled to a copy of the notice currently in effect.
- I am required to inspect your official photo identification (driver's license or other identification) to protect you against identity theft.
- I will contact you only via means by which you give me permission (phone numbers, email address) and I may occasionally call you to remind you of appointment times at your designated number or email.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may file a complaint with me at my office.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, 2201 Sixth Avenue, Suite 900, Seattle, WA 98121-1831 (Phone 206-615-2287, FAX 206-615-2297, TDD 206-615-2296).

You will not be penalized for filing a complaint.

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FEE AGREEMENT

Payment Plan: We agree that payments or co-pays for service are due at the time of service and the responsibility for payment is the clients. Denial of payment by an insurance carrier or other third party does not waive the client's responsibility to pay.

Please initial your consent:

_____ I intend to pay in full for the session or co-payment at the time

services are rendered with check/cash or debit/credit card.

_____ (Initial) I will pay $115 per 50 minute session.

_____ (Initial) I understand that a no-show or late cancelled session (less than 24 hours notice) will be charged a fee of $65.

Date _____

Printed Name _____

Signature _____

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Consent to Treatment

I, the client, understand that I have the right now to sign this form. My signature below indicates that I have read and discussed this agreement; it does not indicate that I am waiving any of my rights. I also understand that any of the points in this document can be discussed and may be changed by mutual agreement at any time. I understand my rights to privacy and the exceptions to my rights to privacy, and that there are risks associated with counseling. I have read, or had read to me this document as well as the Notice of Privacy Practices document. I have discussed those points I did not understand and have had questions, if any, fully answered. I agree to the points in this document and enter into counseling with this therapist as shown by my signature here.

Printed Name _____

Signature _____

Date _____

Printed Name _____

Signature _____

Date _____


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