Informed Consent Agreement

Prior to beginning a counseling relationship, it is important for you to familiarize yourself with my approach to treatment, your rights and responsibilities, and my office practices. You have received my Professional Disclosure Statement and Notice of Privacy Practices. These documents outline your right to confidentiality and privacy and define under what circumstances your health information may be released to another person or agency.

Assessment and Treatment Planning

To provide the best possible care, it is important that I have a clear understanding of what brings you to see me. To assist in this process, I will ask about your past and current functioning, past and current mental health problems, previous treatment, and alcohol and drug use. Some of the questions may seem unrelated to the reason you are coming to see me, but it is important for me to have this information so that I can provide treatment that will lead to a happier and more satisfactory life for you.

It is critical that you candidly discuss your treatment needs. If at any time you feel misunderstood or feel that the counseling or treatment is misguided or not right for you, please bring this to my attention. Open communication is essential throughout treatment, so I will ask for your feedback about how the counseling is going for you on a regular basis.

To meet the treatment goals, you will be asked to experiment with new behaviors and activities, both during our sessions and between sessions. If these activities and behaviors do not work for you, please let me know.

Risks to Counseling and Treatment

There are risks involved in counseling and treatment. For example, some people experience an increase in stress during the early stages of counseling. Some problems may seem to get worse before they get better because you are focusing more attention on them. In some cases, discussing long-standing, unresolved problems brings them to the surface and can seem to aggravate rather than help the problem. This may happen in couples or family counseling. Other risks may occur as well, depending on your unique situation. Please ask me about what risks you can expect and I will also discuss other risks as I identify them.

Counseling and Treatment Alternatives

I am not able to treat all concerns and problems and cannot guarantee successful treatment. If I determine that I cannot adequately treat you, I will inform you at the earliest opportunity and assist you in finding services that are more appropriate. This could include referral to another mental health provider, a hospital inpatient program, or a substance abuse program. Other referrals may also be important. If at any time you have doubts about the appropriateness or effectiveness of your treatment with me, please discuss these doubts as soon as possible.

Legal Proceedings and Court Involvement

If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how your involvement in legal proceedings might affect our work together. If you have been asked to obtain an evaluation for a legal proceeding, I will assist you to find a provider who provides the evaluation you are required to obtain.

Clients entering treatment are agreeing to not involve me in legal or court proceedings nor attempt to obtain treatment records for legal or court proceedings when marital or family counseling has not been successful at resolving disputes.

If you do require my testimony or involvement in legal or court proceedings, I will do so only with your consent unless I am subpoenaed by the court to appear or produce records related to your treatment with me. My fee for appearance is $175 per hour from the time I leave my office until I return to it after the court appearance. My fee for records is as established by the state of Oregon or the state of Washington, as applicable.

Appointments and Cancellations

Our sessions will be by appointment and usually will be 55-60 minutes long. Please call or text **503.963.9332** as soon as possible if you need to cancel or reschedule your appointment. Full payment will be expected for cancellations made with less than 24 hours notice, with very few exceptions.

Emergencies

In the event of an emergency related to your treatment with me, you may call or text my office number and leave a confidential message. I will return your call as soon as I am able, usually within the day. Please identify that you are having an emergency and leave a call back number. If I cannot be reached immediately by phone when you need emergency help, you can call 911. If you feel that you might hurt yourself, go to the nearest hospital emergency room.

Vacation and Backup Coverage

I will inform you when I plan to be out of town and unavailable by phone, in which case I will inform you of the name and number of a backup counselor.

Payment and Billing

It is my policy that you will pay for your treatment at each office visit. If you plan to use insurance, please contact your insurance provider and ask about your out-of-network benefits. *I am out of network with all insurance companies*. I will bill your insurance company online to expedite reimbursement for you.

All insurance coverage requires that you have a diagnosable psychiatric condition. If you do not have a diagnosable condition that qualifies you for insurance coverage, I will inform you as to your treatment payment options. Regardless of the insurance company's handling of your claim, you are responsible for all charges.

By signing this Informed Consent Agreement, you are authorizing the release of any medical or other information necessary to process your claim, should you choose to request insurance involvement. If you have not fully paid for services rendered, you are authorizing payment of insurance benefits to Melissa Owens LPC, LMHC to cover the balance due.

Agreement and Consent for Counseling and Treatment

I have read the information in this Informed Consent Agreement and have been given the opportunity to ask questions about it. I understand my rights to privacy, the exceptions to my rights to privacy, and that there are risks associated with treatment. I agree to abide by the payment and billing policy outlined above and accept full responsibility for any and all fees incurred for my counseling.

_____ _____

Printed Name Date

_____

Signature

_____ _____

Printed Name Date

_____

Signature