

492 East 13th Ave., Suite 204
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INFORMED CONSENT FOR SERVICES

I _____ agree and consent to receive mental health treatment provided by Cecilia Escobedo, Licensed Marriage and Family Therapist. My request for services is voluntary and I may discontinue services at any time.

If I am an adolescent age 14 or older, I have the right to access services without consent from my parent/guardian.

My parent/guardian will be involved before the end of services unless they refuse or there are clear clinical reasons not to involve them, which will be documented in my record.

I am the holder of privilege within the therapeutic setting. Information that is discussed during services is confidential and no information about my case can be released to anyone other than Cecilia Escobedo without written authorization from me, with the following exceptions: if during services, I reveal to Cecilia Escobedo past or threatened abuse of a person who is in a protected category, whether that person is myself or another individual, she must disclose and report such information as required by Oregon law. Individuals in the protected categories are children, elderly persons, developmentally disabled persons; if I threaten to harm myself or others, Cecilia Escobedo is required to intervene, which may include a report to the appropriate agency and/or authority. In the event of threatened harm to any individual, Cecilia Escobedo may warn the intended victim(s) by the most efficient means available.

In cases of psychiatric hospitalization, information about mental health status prior to hospitalization and information judged to be helpful in-service conclusion planning may be released. Any information shared will be documented in my record.

If a child abuse investigation is being conducted, this writer is required under Oregon law to permit the investigating agency to inspect and copy records of the child involved in the investigation without the consent of the child or the parent/guardian of the child.

If I am involved in or anticipate being involved in legal or court proceedings, I will notify Cecilia Escobedo as soon as possible to help them understand how, if at all, their involvement in these proceedings might affect our work together. Cecilia Escobedo will not volunteer confidential information within a court proceeding without my written permission.

If I am covered by a third-party payer, I authorize billing to my health plan and payment of benefits directly to Cecilia Escobedo, LMFT.

I received a copy of the following information at intake: Consent for Services, Notice of Privacy Practices and No Show/Late Show Policies.

Scheduling and Cancellations

I agree to keep scheduled appointments with my therapist.

I will provide at least 48 hours advance notice if I need to cancel an appointment.

Co-payment is due at the time of services. Cash or checks are the only accepted methods of payment. Please, call your insurance company prior to the intake appointment in order to obtain this information.

My signature affirms that I have read and understand this form and have had the opportunity to ask questions.

Client's signature

Date

Parent/Guardian