**Informed Consent for Treatment**

Welcome to my practice. This document contains important information about me, the services I provide, my business policies, and your rights as a client. Please read it carefully and ask any questions you may have about this information. Signing this document will constitute an agreement between us and mark the beginning of our therapeutic relationship.

**About me**

I am a clinical psychologist associate resident in Oregon registered with the Oregon Board of Psychologist Examiners. A psychologist associate resident is a pre-licensed mental health professional working under the clinical supervision of a licensed psychologist. Thus, while I am seeking licensure, Dr. Elsbeth Martindale, PsyD (OR license #963) supervises my clinical work.

I earned my degrees in clinical psychology and research psychology from Pacific University in August 2018, after serving my internship at the Oregon State Hospital Acute Forensics Unit. Prior to my graduate degrees, I earned my bachelor’s degree in psychology and writing from Western Oregon University. I have focused on working with acute mental illnesses and comorbid disorders in a culturally diverse environment. Additionally, I have specialized my clinical and research background in mindfulness, relationship and sexual satisfaction.

**Psychological Services**

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life.  However, psychotherapy has been shown to have benefits for individuals who undertake it.  Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems.  But there are no guarantees about what will happen.  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.

**Philosophy**

I seek to build collaborative relationships with my clients to more effectively understand the issues they may be dealing with and to help find ways to resolve them. I use my clinical expertise to integrate various psychological theories and techniques, tailoring the therapy experience to each clients’ needs and personality. The techniques I use are grounded in classical and empirically based psychological theory. I value and encourage continual feedback from clients about how the therapy experience and relationship is working for them.

**Fees**

The fees for my service are as follows:

Intake session (60 minutes): $75

Individual session (60 minutes): $75

Phones calls longer than 5 minutes: $50

Group session (60 minute) $50

On a limited basis, we may agree on a reduced fee if your financial status warrants it. The reduced fee will be within an established “sliding scale” of payment and is only available to a certain number of clients at a time. Payment agreements outside of my normal fees will be documented, kept on file, and reviewed quarterly to determine continuing eligibility.

If you become engaged in legal proceedings and request or require my participation, please understand that this detracts from my regular work and other clients. Thus, my legal fee of $150 per hour applies to any time spent on the entire court process, including but not limited to consultation with attorneys, travel time, waiting to testify, preparing written briefs, and actual testimony.

**Payment**

Payment of our agreed upon fee is due at the time of service. I am not contracted with any insurance companies, but I will provide a receipt that you may submit to out-of-network insurance plans for reimbursement. It is important that you contact your insurance company to inquire about mental health benefits before we begin working together and understand how much of my fee your insurance will reimburse to you. Please remember that your insurance policy is an agreement between you and your insurance company, and that you are ultimately responsible for paying the fees we have agree upon.

I take payments in the form of credit cards or cash. I will not provide services if services are not paid for at the time of service unless we have agreed on a payment plan.

**Scheduling & Cancelation**

Session are made by appointment only. Sessions last 60 minutes. Each client I work with will have a tailored treatment plan which will be determined by both need and affordability. Once you schedule an appointment, you are expected to pay for it in full. If you are late, I will end the session on time to maintain my schedule for other clients.

*Missed or Cancelled Sessions:*

Therapy is a commitment. I do not have a 24-hour cancellation policy. I charged my full fee for missed/cancelled sessions. If you can reschedule your appointment for a later time the same week, I can make an exception. If we discuss and agree on the circumstances of the missed/cancel appointment you will not be charged.

*Appointment Reminders*

 I do not call clients to remind them of upcoming appointments.

**Contacting Me**

I am typically in the office from 10:00 AM to 6:00 PM Monday, Tuesday, Wednesday and Friday; Thursdays I am available by appointment only. Saturday and Sunday, I am available for emergencies only (my normal fee is doubled). I am out of the office on Major Holidays.

It is my policy to not answer the phone when I am with a client, so I am often not immediately available. When I am unavailable, my phone will be answered by voice mail. Please leave a message and I will return your call as soon as possible. You may also contact me via e-mail or text message if you prefer, and I will respond in kind and in the same timeframe as a phone message. Please do not include confidential information in your voice message, text message, or e-mail. In the digital era, it is safest to consider only face-to-face contact as confidential.

If you need support immediately and cannot wait for me to return your message, please call the **Marion County Psychiatric Crisis Center at 503-585-4949.** If you believe you may be a risk to the safety of yourself or others, please call 911 or go to the nearest emergency room or hospital.

**Professional Records**

The laws and standards of my profession require that I keep treatment records, including diagnoses, treatment plans, and progress notes. Your mental health records are maintained in an encrypted HIPAA compliant cloud storage program called Dropbox. You have a right to receive a copy of your records, or I can create a summary if you prefer. I recommend that you review them in my presence so that we can discuss the contents, as this will help avoid misinterpretation, confusion, and unnecessary distress. Please note, I charge an appropriate fee for any professional time spent in responding to information requests. You have the right to fully understand your treatment plan and to ongoing review of your treatment plan. We will collaboratively generate initial goals for therapy, and I will periodically review the plan both independently and with you. If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records.

**Confidentiality - Rights & Limitations**

Information that you share in treatment is held in the strictest confidence possible under law, however there are some limitations to address at the time of consent. As noted in my Notice of Privacy Practices, the following exceptions to confidentiality apply:

Abuse of Children, Elderly Persons, Mentally Ill Adults, Developmentally Disabled Adults, or Animals: If I have reasonable cause to believe that a child or elderly person has been abused (by you or another party), I may be required to report the abuse.

Domestic Violence: If I have reasonable cause to believe you are the victim or perpetrator of domestic/partner violence that is impacting children, I may have an ethical obligation to disclose your PHI to prevent harm to you or others.

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.

Judicial or Administrative Proceedings: If (a) You become involved in a lawsuit, and your mental or emotional condition is an element of your claim; or (b) A court orders your confidential information to be released or orders your mental evaluation.

Health Oversight: The Oregon State Board of Psychologist Examiners may subpoena relevant records from me should I be the subject of a complaint.

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.

Even in these cases I will preserve your privacy to the best of my ability. Any third-party requests to release your information will need to be reviewed and approved by you. You have the right to request and understand information shared, with whom it is shared, and for what reason it is shared. Please see your notice of privacy rights for more information.

If you are using health insurance to pay for therapy, your insurance company may ask for information about your symptoms, your diagnosis, and my treatment methods. If they do, I will inform you of the information they have requested. I will provide only as much information as the insurance company requires to grant your benefits. Please note that I have no control over how these records are handled at the insurance company.

As a psychologist associate resident, I am required to consult with my supervisor about all of my clients, including disclosing your confidential information. This helps ensure I am providing you the best care possible. My supervisor and all members of the supervision group to which I belong are bound by the same ethical and legal standards of confidentiality as I am.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have as soon as they arise.

**Scope of Practice**

My role in our therapy relationship is strictly My role in our therapy relationship is strictly to provide mental health services. Any and all medical questions, including those pertaining to medications, must be directed to a medical professional. I will provide referrals to appropriate providers if you wish. It is my policy to collaborate with your other providers to help ensure you receive comprehensive, informed, integrated care. Doing so requires your written consent on a separate release of information. You are free to decline or revoke such consent at any time within the provisions noted in my Notice of Privacy Practices.

**Client Rights**

If at any time you feel that this psychotherapy relationship is not beneficial, you have the right to seek other services to best help with your needs. I will provide resources should you need them. You have the right to be fully informed before you begin a psychotherapy relationship. Any questions or concerns are welcome and encouraged.

**Consent to Treatment**

Your signature below indicates that you have read and understood this document, that you have received and reviewed a copy of the Notice of Privacy Practices, and that any questions you may have were answered to your satisfaction. Further, your signature indicates your agreement with the terms of this document and your desire to enter into therapy with me. Thank you for inviting me to embark on this journey of exploration and growth with you.

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Clients Signature Date

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Clients Printed Name

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Shyn Childress, M.A.

Psychologist Associate Resident