**Dena L. Shehab, Psy.D.**

**Licensed Clinical Psychologist**

**2311 NW Northrup Street, Suite 201, Portland, OR 97210 (503) 709-8503**

**AGREEMENT FOR INFORMED CONSENT TO TREATMENT**

Welcome to my psychotherapy practice. Thank you for taking a moment to read this important information about my professional services and policies. Please read it carefully and ask me any questions you have about it.

# CONFIDENTIALITY

The confidentiality of what you share in therapy is extremely important. I am obligated by Oregon State Law and the American Psychological Association Code of Ethics to protect your right to confidentiality. This means that I must have your permission before revealing any information about you to anyone, with the following exceptions:

1. If you communicate a serious threat of *physical* *violence against another person*, I am permitted by law to take steps to protect the person(s) in danger. These steps include notifying the potential victim who is being threatened, calling the police, or seeking hospitalization for you.
2. If you threaten to cause *severe harm to yourself*, and I believe the threat is serious, I am ethically required to try as best I can to protect you. This might include talking to you about voluntarily going to a hospital, contacting a supportive family member or friend, calling the crisis team or police, or having you placed in a hospital even without your permission.
3. If I suspect that you or someone you know is *abusing or neglecting a child*, or that you are *abusing or neglecting an elderly, mentally ill or dependent adult*, I may be required to report the abuse.
4. If you are or become involved in any kind of *lawsuit* or administrative procedure, and you or your attorney would like to tell the court about your mental or emotional health, you may not be able to keep your records or your therapy private in court. Also, if you bring a legal action against me as your psychotherapist, you will not be able to keep your records or your therapy private in court.
5. If I receive a *subpoena or a court order* asking for your records, I will take steps to limit such access; though I may be required to give the court the specific information it wants.
6. In order to provide you with the best treatment I can, there will be times when I seek *consultation* form other licensed mental health professionals.

Any professional with whom I consult is required to maintain confidentiality,

**AGREEMENT FOR INFORMED CONSENT, P.2**

though exceptions to privacy apply to them as well. I may also find it beneficial to consult with your other health care providers. I will discuss this with you in advance and will ask you to sign a release of information form.

# BENEFITS AND RISKS OF TREATMENT

Most people who participate in therapy benefit from it. Effort on your part, a willingness to try to be open with yourself and your therapist, and a desire to improve some part of your life make it more likely that therapy will help.

Therapy does have some risks. Remembering and resolving unpleasant events through therapy can bring on uncomfortable feelings. Also, therapy may bring on changes in your relationships. It is important that you discuss your feelings and concerns about this too. Yet because therapy helps people deal with their feelings more effectively, many find that the positive benefits outweigh their discomfort.

# PAYMENT POLICIES

**Fee.** My fees are as follows:

50 minute initial psychotherapy consultation $250

50 minute individual psychotherapy session $180

60-minute individual psychotherapy session $200

60-minute couples therapy session $200

Phone call between sessions (>5 minutes) $15/5 minutes (or portion therein)

I have a limited number of hours set aside for working with people who cannot afford my full fee. If my full fee poses a financial hardship for you, we may discuss your situation and may agree on a discounted fee for as long as your circumstances require it. Over the course of our work together, I may raise your fee to reflect changes in the cost of living. I will always discuss such adjustments with you beforehand.

**Payment.** Payment by cash, check, or credit card is expected at the time of service. If you are being referred by your health insurance company, please be prepared to provide me with a copy of your insurance card and other relevant documentation. Should your insurance deny reimbursement of any services, you will be held responsible for the full payment of those services.

# AGREEMENT FOR INFORMED CONSENT, P.3

**Appointments, Cancellations, & Missed Sessions.** Appointments will typically be scheduled on a regular basis. Once arranged, I set aside time in my schedule for that purpose and hold your hour for you from week to week. If you must cancel an appointment, I need to be notified at least 48 hours in advance. You are financially responsible for all appointments which you miss without such notice or cancel late and will be charged at your regular per-session rate. If we are able to reschedule your missed appointment within the same week, the additional charge will be waived. There is no charge for any regularly scheduled appointments that occur on a holiday or during my absence.

Please be advised that insurance companies will not cover missed appointments and so this means you are responsible for the full payment of such sessions.

**ELECTRONIC COMMUNICATIONS & SOCIAL MEDIA POLICY**

These policies have been developed in an effort to protect your confidentiality, respect your and my privacy, and maintain clear boundaries within our therapeutic relationship.

* I do not accept friend or contact requests from current or former clients on any social networking site (including, but not limited to Facebook, LinkedIn, Twitter, etc.)
* I will not “follow” you on Twitter, Instagram, any blog that you contribute to, etc. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can explore them together.
* It is NOT a regular part of my practice to search for clients on Google, Facebook, or other online sites. Extremely rare exceptions may be made during times of crisis (for example, if there is concern for your safety or that of someone else, as detailed in my “Confidentiality” above), if we have not been in contact or I can’t reach you via our usual means (appointments, phone, email, text).
* My preferred way of interacting outside of our sessions is by phone/voicemail (see “Contacting Me” below). While I will respond to text and email messages, please reserve these for limited communications about scheduling and the like, as email and text communications are not completely secure (they may be retained in a log by your or my Internet Service Provider). You should know that any messages or emails you send to me, and my responses to you, become part of your legal, medical record and may be subpoenaed as evidence as required by law.

**AGREEMENT FOR INFORMED CONSENT, P.4**

# CONTACTING ME

If you need to contact me between sessions, please call me at **(503) 709-8503**. If I do not answer, you may leave me a voicemail message and I will make every attempt to return your call within 24 hours. If you feel you are having a mental health crisis and need to speak with someone urgently, please leave me a message, and then call 911 or go to your nearest emergency room.

# ACKNOWLEDGEMENT & CONSENT

By signing this form, I am acknowledging that I understand and consent to the information contained in this document, and that I am entering into this arrangement voluntarily. I have also been offered a copy of Dr. Shehab’s privacy policies. I have discussed any concerns I have, and my questions have been answered to my satisfaction. I also understand that I may raise any new questions or ask for clarification as needed in the future.

Client Signature Date

Client Signature Date

Provider Signature Date

cc: 1 copy to client

 1 copy in client record