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INFORMED CONSENT FOR TREATMENT AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. A new federal law, the Health Insurance Portability and Accountability Act (HIPAA) requires that I provide you with a document called the Privacy Notice that explains new regulations pertaining to patient rights and privacy protections regarding the use and disclosure of protected health information. This document is attached to this Informed Consent For Treatment Agreement. The law also requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time except to the extent that I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred. If you have further questions after reading these documents, please ask me about them at our first meeting or at any time thereafter.

BENEFITS AND RISKS OF TREATMENT

It is important to be aware that there are some risks involved in treatment. As problems are faced, clients sometimes experience emotional discomfort along the way. Also, therapy may result in changes in relationships, as when a client changes in ways in which family members, partners, or friends cannot easily accept. I will try hard to limit these risks and to help you be aware of them. There are also many potential benefits of therapy. Through therapy, you may learn new and important things about yourself and others, as well as new ways of handling feelings and problems. But there are no guarantees regarding what you will experience. Ultimately, you must be the judge of whether the potential benefits of therapy outweigh the risks.

CLIENT RIGHTS AND RESPONSIBILITIES

Therapy is a shared responsibility between client and therapist, and it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. You always retain the right to ask questions about my qualifications, my therapeutic approach, or any other aspects of treatment, including treatment alternatives and the possible time frame your treatment may require. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another therapist for a second opinion.

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and use and disclosures of Protected Health Information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of the Privacy Notice and my privacy policies and procedures. These rights are detailed in the attached Privacy Notice. I am happy to discuss any of these.

CONFIDENTIALITY

The information shared by you during the course of our professional relationship will not be disclosed to any other agency or person without your permission. There are, however, some situations where I am permitted or required by law or by ethical standards of the practice of psychology to disclose information without either your consent or authorization. These situations include the following:

Threat to Others: If I believe that a client presents a clear and substantial risk of imminent, serious harm to another person, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client.

Threat to Self: If I believe that a client presents a clear and substantial risk of imminent, serious harm to self, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

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 records containing confidential information.

Abuse of Elderly, Mentally Ill or Developmentally Disabled Adults: If I have a reasonable cause to believe that an elderly, mentally ill, or developmentally disabled adult, who receives 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 have come into contact has abused an elderly, mentally ill, or developmentally disabled adult, I may be required to report the abuse. In any investigation pertaining to the alleged abuse of an elderly, mentally ill or developmentally disabled adult, I may be compelled to turn over records containing confidential information.

In any situation involving potential harm, including abuse, it is important to note that I have an ethical obligation to prevent harm to my client and others. In such situations, I will use my professional judgment to determine whether it is appropriate to disclose confidential information to prevent harm. In such cases, 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: Your otherwise confidential information may become subject to disclosure in legal proceedings if any of the following occur:

1. If you become involved in a lawsuit and your mental condition is the element in the claim, or
2. A court orders your PHI to be released or orders your mental evaluation.

Health Oversight Activities: If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

Defense Against Lawsuit: If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

Worker's Compensation Claim: If a client files a worker's compensation claim, he/she automatically authorizes me to release any information relevant to that claim. This would include a past history of complaints or treatment of a condition similar to that involved in the worker's compensation claim.

Medical Emergency: If I have reasonable cause to believe that you are experiencing a medical emergency and that you need immediate assistance in order to prevent death or serious health consequences, I may take steps to obtain immediate medical assistance that may involve disclosure of otherwise confidential information.

Parents of Minors: Patients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents (both custodial and non-custodial) to examine their child's treatment records.

Payment Collection Purposes: You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. You should also be aware that I may make disclosures about otherwise confidential information to the extent that it is necessary to collect overdue fees. These disclosures are discussed elsewhere in this Agreement.

With your consent (as documented by your signature at the end of this document), but without additional specific written authorization, I may make disclosures about your otherwise confidential health information in the following situations:

Consultation: I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort not disclose any information that is detailed enough to be personally identifying of a particular client. The other professionals are also legally bound to keep the information confidential.

Business Associates: I have a contract with a professional who performs bookkeeping services. I disclose to him only that information that is required for him to perform his duties. As required by HIPAA, I have a formal business associate contract with this individual, in which he promises to maintain the confidentiality of

this data except as specifically allowed in the contract to perform his duties or otherwise required by law. On request, I can provide you with more information.
It is my policy to make disclosures other than those listed above only with written authorization specifically granting me permission to do so. While this written summary of exceptions to confidentiality should prove helpful in informing you about disclosures of otherwise confidential information, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL FEES

The fee for an initial evaluation session is $250.00. The fee for routine forty-five minute psychotherapy sessions is $250.00. I also charge for any other professional services that a client may request of me or which are necessitated in order to meet appropriate standards of care, including but not limited to client initiated phone or email consultations and staffings with other professionals involved in your treatment. For these services, I charge the hourly rate for routine psychotherapy sessions that has been established, pro-rated in quarter hour increments. These services are generally not reimbursed by insurance companies. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty and complexity of legal proceedings, I bill at an hourly rate of $200.00 per hour for these services.

MISSED APPOINTMENTS

If you must cancel an appointment, I need to be notified at least 48 hours in advance. Unless other arrangements are agreed upon, I will charge the regular session price for appointments missed without adequate advance notice. Consistency is an important factor in making progress in therapy. Even with adequate advance notice, frequently cancelled appointments are problematic. If this becomes a regular pattern, we will need to discuss whether continued treatment is advisable.

INSURANCE AND PAYMENT

In most cases, full payment for services rendered is expected at the time of service. In limited cases, however, I bill insurance companies on clients' behalf. In these situations, I am willing to accept only a co-payment at the time of service. When this is the case, you are consenting to have the insurance company reimburse me directly for the balance of the full fee. However, please be advised that the ultimate responsibility for payment of services rendered is still the client's. If an insurance company denies a claim for whatever reason, the client will be responsible for the payment in full. It is the client's responsibility to be aware of the extent and limitations of coverage. If you have questions about your coverage, please contact your insurance company directly. If you choose to use insurance coverage to pay for services, you should be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. If you have an Oregon insurance policy with the state law requirement that by accepting policy benefits, you are deemed to have consented to examination of your Clinical Record for purposes of utilization review, quality assurance and peer review by the insurance company, then I may provide clinical information to your insurer for such purposes. Sometimes I am required to provide

additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

BILLING

It is my practice to send monthly statements to clients with a balance that insurance is not expected to reimburse or has declined to reimburse. If you receive a statement indicating that payment is due, payment is expected within 30 days of receipt of that statement. If the account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. I release only that information relevant to and necessary for the collection of payment due.

CONTACTING ME

Due to the nature of my work and my work schedule, I am often not available by telephone. If you leave me a message on my voice mail, I will attempt to return your call within 48 hours unless it is a weekend or holiday. If you are experiencing a mental health emergency, please state this in your message. If you need immediate support and I am not able to respond to your message promptly, please call the crisis line at (503) 988-4888 or go to your nearest hospital emergency room. If I will be out of town for an extended period of time, I will arrange for on-call coverage with another psychotherapist.

CONSENT FOR TREATMENT AND TO THE TERMS OF THE AGREEMENT

I have read this statement of policy and understand its contents. I have asked any questions I have had about these policies. I voluntarily consent to therapy from Dr. Bridget Fanning-Ono under the terms described above and understand that I have the right to terminate therapy at any time I desire.

Name of Client (Print):_____

Signature of Client or Legal Guardian:_____ Date:_____

I acknowledge that I have received a copy of the Privacy Notice detailing HIPAA regulations:

(Client/Guardian Signature):_____ Date:_____

I give consent for Bridget Fanning-Ono to release to my health insurer information relevant to the services I have provided to you. Such information includes but is not limited to: diagnosis, treatment plan, symptom status, functional impairment, treatment compliance, response to treatment, and progress toward treatment goals.

Signature of Client/Guardian:_____ Date:_____