AGREEMENT AND INFORMED CONSENT FOR TREATMENT

Treatment Agreement

Welcome. I appreciate the opportunity to serve you as a counselor. This document (the AGREEMENT) contains important information about my professional services and business policies, as well as summary information about the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA is the federal law that provides for privacy protections and patient rights regarding your Protected Health Information (PHI). HIPAA regulations require that I provide you with a NOTICE OF PRIVACY PRACTICES (the NOTICE) regarding the use and disclosure of your PHI. The law also requires that I obtain your signature acknowledging that I have provided you with this information at the start of treatment. Although these documents are long and sometimes complex, it is important that you read them carefully before signing. You will also receive copies of this information for your records. If you have any questions or concerns about this information, please let me know so we can address them.

When you sign the AGREEMENT, it represents a formal agreement between us. You may revoke this agreement in writing at any time, and that revocation will be binding unless (1) I have already taken action in reliance upon it, (2) there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy, or (3) you have not satisfied financial obligations incurred by you.

Please keep a copy of this office policy statement for your records. A second copy, signed and dated, will be kept in your file. It is important you read the entire statement carefully and ask any questions you may have before signing.

Psychological Services

As we work together it will be important for us both to assess the process. Our first few sessions will allow us to evaluate your needs and goals for therapy, and to decide whether I am the most appropriate professional to assist you with those issues. You should evaluate your sense of comfort in working with me professionally on those issues as well. If you have any questions about our work together, please discuss them with me when they arise. I assure you that I will handle our therapy relationship in a professional and ethical manner, consistent with the accepted standards and guidelines of my profession.

Psychotherapy often involves discussing difficult or unpleasant aspects of your life and you may experience uncomfortable emotions such as sadness, guilt, anger, loneliness, helplessness, and frustration. On the other hand, psychotherapy has been shown to have benefits for people who go through it. Therapy can often lead to better relationships, solutions to specific problems, significant reductions in feelings of distress, and increased self-awareness and self-acceptance. However, I am unable to guarantee you any specific result or experience in the psychotherapy process

Confidentiality

As a Licensee by the Oregon Board of Licensed Professional Counselors, I subscribe to the APA Revised Ethical principles. I abide by the laws and ethical principles that govern privilege and confidentiality. I maintain confidentiality in creating, storing, accessing, transferring, and disposing of records in any medium. Your Clinical Record includes your reasons for seeking therapy, how your life is being impacted, your diagnosis, the goals we have set for treatment, your progress toward those goals, your medical, social and treatment history, any past treatment records I receive from other providers, reports of any professional consultations, your billing

records, and any reports that have been sent to anyone per your request. Your billing records include your contact information and billing statements. All records and notes are kept locked or password protected, and all records are retained for a minimum of seven years as required by law. In the event of your death, the privilege to access your record passes to your estate. In the event of my own incapacitation, withdrawal, or death, another licensed professional will assume responsibility for my records.

By submitting a written request, you may examine and/or receive a copy of your Clinical Record, except in circumstances where disclosure would be injurious to you or would constitute an immediate and grave detriment to your treatment. In such circumstances, I may provide you with an accurate and representative summary of your Clinical Record, if requested. Professional records can be very confusing and/or upsetting to an untrained reader. For this reason, I recommend you review them in my presence or with another mental health professional. In most circumstances, I will charge a copying/printing fee of 25¢ per page. If you wish to review your Clinical Record, please address your request to me, so we can discuss the best way to make this happen.

In general, the law protects the privacy of all communications between a client and a counselor. I will not disclose anything you tell me, not even the fact that you are a client, without your written permission via a signed release of information form. There are a few **exceptions** to these standards:

1. It is legally required of me to act so as to prevent physical harm to others or to society when there is "clear and imminent" danger of that happening.
2. I am ethically bound to act to protect you or others from harm.
3. I am ethically bound to report cases of ongoing child, elder, and disabled abuse.
4. I may have to release clinical information regarding your treatment to insurance carriers as required for payment or review of your claim.
5. I may have to release your records when ordered to do so by court subpoena or judge order. However, I will discuss the details of privilege with you beforehand and request a written release from you if I judge this to be in your best interest. In some cases involving child custody and those in which your emotional condition is an important issue, a judge may order the release of your information if he/she determines that the issues demand it.
6. I may also release information about you in my defense if you file a complaint.
7. I may use electronic transmission to send treatment plans, reports or evaluations to your insurance company, specific agencies or other providers.
8. Email correspondence is not confidential unless using encrypted means such as Send, Inc.
9. I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to protect the identity of my clients. The consultant is also legally bound to maintain confidentiality.

Electronic Confidentiality: You agree to transmit therapeutic email using encrypted means such as Send Inc. If you are unable to submit therapeutic email via Send, Inc., please know that I cannot guarantee the privacy and confidentiality of information submitted and that you take full responsibility for sending information in a manner other than encrypted means. Please understand that text messages are not confidential. You agree to keep computer files referencing our communication using secure and encrypted measures. Determine who has access to your computer and electronic information from your location. This would include family members, co-workers, and friends. I encourage you to only communicate through a

computer when confidentiality can be ensured. Be sure to fully exit all online counseling sessions and email before leaving your computer.

Couple's Therapy

The goal of couple's therapy is unique to each couple, whether it is reconciliation, improved communication, or an amicable separation. It is important that both partners feel safe in disclosing his or her feelings and thoughts about the relationship. In order to facilitate this safety, I do not hold secrets, and any contact (e.g. telephone messages) made between sessions by one partner will be disclosed to the other partner. Your record as a couple is also confidential and both partners must sign the appropriate documentation to release records to an outside source.

Legal Proceedings

It is important for you to know that I am not a forensic psychologist or a child custody evaluator. I will not be a party to legal proceedings against current or former clients. My goal is to support my clients to achieve therapy goals, not to address legal issues that require an adversarial approach. Clients entering treatment are agreeing to not involve me in legal/court proceedings or attempt to obtain records of treatment for legal/court proceedings when therapy has been unsuccessful at resolving disputes. This prevents the misuse of your treatment for legal objectives.

Appointments

Appointments are usually scheduled for the same time each week. Therapy sessions are approximately 50 minutes in length. Your regular appointment time is reserved for you and you are financially responsible for the scheduled time. In the event that you are unable to keep your appointment, please notify me immediately. You will be expected to pay for the scheduled time unless you provide **72 hours** advance notice of cancellation. If possible I will try to reschedule your cancelled appointment. If you miss a session without notice you will be financially responsible for the session you missed; insurers do not reimburse for missed sessions.

Telephone Calls, Email, and Emergencies

My office phone number is **(503) 320-4556**. I check my messages regularly; however there will be times when due to personal or professional commitments I am unavailable. If my absence is expected, I will leave information regarding who is on-call on my voicemail message. If no one can be reached and your call is an emergency, you may call 911 to receive emergency assistance. You may also call the Multnomah County Crisis Line at 503.988.4888. Because voice mail technology is not error proof, if you have not heard back from me by the end of the next day, please feel free to call again since it is likely that I did not receive your original message.

I use my email address primarily to send documents to you when necessary. All other contact should be through phone and voice mail. This is primarily due to the unreliable and un-secure nature of email other than using encrypted email like Hushmail. Although I do regularly check my email, it is not a good way to reach me in an emergency.

Safety Policy

Staff and client safety are of utmost importance. As such, any act of aggression to self, others, or property while on site may be grounds for compensation for damages, legal action and/or immediate termination of services.

Fees

My fees for therapeutic services are the following: $175 per Intake session, $150 per Individual session, $160 per Couples session. 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 of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

There is a $25.00 processing fee on returned checks. Payment for the returned check amount plus the processing fee must be paid before your next scheduled appointment.

You are agreeing to pay for all services provided prior to the discontinuation of treatment. You can discontinue treatment at any time by phone or in person. If your account is not paid within 90 days, I have the option of using legal means to secure payment. This may involve the use of a collection agency or small claims court. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, and amount due.

Insurance

While I will do my best to assist you with your insurance benefit, it is important for you to call and find out exactly what mental health services your insurance policy covers and if you are required to obtain preauthorization for services. You should carefully read the section in your insurance policy and call your insurance company if you have questions. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis and some require treatment plans, summaries or a copy of the entire record. Though insurance companies claim to maintain confidentiality, I do not have control over your information once it is in their hands.

The contract for professional services and payment is with you. If you choose to use your health insurance coverage, I will submit claims on your behalf. It is your responsibility to notify me of changes to your insurance. You are asked to pay your co-payment or non-covered amounts at the time of service. Mental health reimbursement policies differ dramatically from one third-party contract to another. It is often difficult to predict the services and fees different plans will cover. For this reason, it is important to discuss these issues in your early sessions or when there is any change in your insurance to avoid confusion and problems that could interfere with our work together. It is important to note that even when I have filed an insurance claim on your behalf, if after 90 days I have not been paid by your insurance company, you will be required to pay the past due balance. While I do my best to collect on past due insurance claims, I cannot accept responsibility for following up on past due or disputed claims. Regardless of the insurance company's handling of the claim, you are responsible for all fees.

Initials_____

CONSENT TO TREATMENT

I have read and understand this **Agreement and Informed Consent for Treatment** in its entirety. Fee arrangements and terms of confidentiality have been clearly made. My signature below indicates that I agree to all terms herein, and I have received a copy of this Agreement upon request, and that I wish to enter treatment on these conditions**.**

_____	_____	_____
Client Signature	Printed Name of Client	Date
_____	_____	_____
If minor, Signature of Legal Guardian	Printed Name	Date

I, the therapist, have discussed the issues above with the client and provided a copy for their records.

_____	Joseph Parrish, LPC	Date_____
Provider Signature	Printed Name	

By signing this form, I agree that I have read been provided with a copy of the ***Notice of Privacy Practices for Protected Health Information and Professional Disclosure Statement*** *for the office and practice of Joseph Parrish, LPC.*

Insurance Information Sheet

(Only complete the top section if your insurance is provided through a spouse or family member.)

Insured's name_____DOB_____
Address_____City_____State_____Zip_____
Client's relation to insured__Phone_____
Insured's employer_____

Primary insurance company_____
Address_____City_____State_____Zip_____
Phone_____
Identification#:_____Group#:_____

Benefit Information:
No. of visits per year_____No. of visits remaining_____Renews:_____
Co-pay:_____
Deductible amount $_____ Deductible met _____yes; _____no.
If no, how much left_____
Preauthorization required _____yes; _____no.
Name and number of contact for preauthorization_____
Authorization #:_____
Limits of health benefit _____yes; _____no.

Insurance Notes:

Initials_____

Joseph Parrish, LPC *10725 SW Barbur Blvd, Suite 40 Portland, OR 97219* *503-320-4556*
P.O. Box 42523, Portland, OR 97242

FINANCIAL AGREEMENT

Insurance Authorization:

Joseph Parrish, LPC has my permission to bill my insurance company(s) and to provide necessary information for the purposes of obtaining authorization for services, benefit information, and payment. I agree that payments or copays for services are due at the time of service and the responsibility for payment is mine. Denial of payment by an insurance carrier or other third party does not waive my responsibility to pay. I understand that no show or late cancelled sessions (**less than 72 hours notice**) will be charged to me at full fee and cannot be charged to my insurance company and that there is a returned check processing fee of $25.00.

_____ _____
Signature Date

Cash Payment Agreement:

I, _____, am choosing to make cash and/or credit/debit payments for the clinical services I receive with Joseph Parrish, LPC. I am doing this for the following reason (s):

☐ I do not presently have insurance with mental health benefits.
☐ I have mental health benefits with _____ (Insurance Company), however:
- ☐ I have exhausted my current outpatient mental health benefits
- ☐ I am choosing not to use my insurance benefits at the present time.
- ☐ I wish to be treated by Joseph Parrish, LPC who is not a paneled member of my insurance network.
- ☐ My concerns are not covered by my insurance benefits or are not deemed medically necessary by my insurer.

My fees are as follows: $175 Assessment; $150 Individual Therapy; $160 Couples;
Other
_____

This agreement pertains to services beginning _____ (date) and will remain in effect until such time as a new written agreement is made, or a valid insurance authorization is obtained and I consent for Joseph Parrish, LPC, to bill my insurance. I agree to make cash payments at the time that services are rendered and also that Joseph Parrish, LPC has permission to bill my credit/debit card if that is the payment arrangement agreed upon. **I also authorize Joseph Parrish to bill my credit/debit card if I no show or cancel my appointment with less than 72 hours notice.** If I choose to use a credit or debit card for payment of services, I agree to pay the transaction charges associated with using applications such as Square.

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Client Information Sheet

Name_____Date_____
Date of Birth_____Age_____Marital Status_____
Driver's License #_____
Home Address_____City_____State_____Zip Code_____
Home Phone_____Cell Phone_____Fax_____
Can I leave a message? _____yes;_____no. Can I identify myself and my profession? _____yes;_____no.

Job title_____Employer_____
Work address_____Work phone_____
Can I leave a message?_____yes;_____no.

Emergency contact_____Relationship_____
Address_____
Work phone_____Home phone_____

Physician_____Date of last visit_____
Address_____
Phone _____

Who referred you to this office?_____
Address_____
Phone_____

Reasons for
referral?_____
_____
_____
_____
_____
_____
_____

Client or authorized person's signature: I authorize Joseph Parrish, LPC to make contact with the referral source to thank him/her and let him/her know contact has been made.

_____ _____
Signature Date

Initials_____

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Intake Information Sheet

Client Name:_____Date_____

Please write down the following information in the space provided.

1. Mental health or general medical illnesses I have had (e.g. depression, anxiety, PTSD, cancer, arthritis, heart, thyroid, neurological diseases, or other illnesses such as migraines, chronic fatigue syndrome, etc.).
   _____
   _____
   _____
   _____
   _____

2. What brings you to therapy? Mental health and general medical symptoms I am currently experiencing and how long (e.g. difficulty sleeping for two months, eating, concentrating, increased irritation for the last six months, feeling depressed or anxious on the weekends, migraines, increased heart rate, chronic fatigue syndrome, HIV, etc.).
   _____
   _____
   _____
   _____

3. Have you been in therapy before? If so, for what issues or under what circumstances.
   _____
   _____
   _____

4. Family of origin information. Mental health issues or medical illnesses that run in my family (e.g. depression, anxiety, schizophrenia, bipolar disorder, diabetes, heart disease etc.).
   _____
   _____
   _____

5. Support System (e.g. family friends, co-workers, etc.).
   _____
   _____
   _____

6. Prescriptions or over-the counter medications that I take regularly (Please include dosages if known).
   _____
   _____
   _____
   _____

7. Substance abuse/Addictive behaviors I have or currently engage in.

_____
_____
_____