Mary Rex MSW Licensed Clinical Social Worker

THERAPY POLICIES AND INFORMED CONSENT STATEMENT

Please read this information carefully and let me know if you have any questions or concerns.

APPOINTMENTS

- Your initial session is considered an evaluation and will last approximately one hour. Subsequent sessions are 45 minutes.
- If you need to cancel or reschedule an appointment, please leave a message on my voice mail. However, **24 hours notice is required**, or you will be charged full fee for that session. Insurance companies cannot be billed for missed appointments.

CONFIDENTIALITY

- Information you give me, and even the fact that you are my client will be kept confidential and only released with your written permission. There are some exceptions to this standard:
  - Oregon law requires exceptions to confidentiality if:
    - I believe you are in physical danger to yourself or others.
    - Physical or sexual abuse of a child, elder or person with a disabling condition is suspected.
    - I am ordered by a judge or subpoena to testify in court.
- I may have to release clinical information regarding you to insurance carriers as required for authorization of treatment, payment or review of your claim.
- I may ask you to sign an Authorization for Release of Information, so that I can discuss your treatment with your physician, previous therapist, or another person or professional involved in your case.
- I may consult with colleagues about my work or in my teaching and supervision of other mental health professionals. If your case is discussed, it will be confidential and without your name or identifying information.

CLIENTS RIGHTS AND RESPONSIBILITIES

Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods of therapy, which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment, to end treatment at any time, or to request a referral to another therapist.

HEALTH INSURANCE

If you are using a health insurance benefit as payment for these services youneed to be aware of what this may mean. Most insurance companies require specific clinical information about you in order to authorize and/or pay for treatment. Health insurance companies usually limit mental health coverage to:

- Services that are considered "medically necessary." This typically means there is evidence of a diagnosis with acute symptoms.

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- Conditions that are treatable by short-term, problem-focused, or goal-oriented approaches whenever possible.

This means your insurance company may only cover a limited number of sessions to address a specific diagnosis or problem. Furthermore, a utilization review / quality assurance group set up by the insurance company or a peer supervision group may review your case or file. In such a situation, your name and identifying information will be kept confidential.

INSURANCE BILLING POLICIES

- If I am on your insurance company's provider list, I have agreed to bill the company directly for my services. You are still responsible for your co-payment, and any deductible you may have at the time of service.
- With other insurance companies, I will gladly file a claim on your behalf, but I may require that you pay the full fee at the time of service.
- I cannot accept responsibility for collecting an insurance claim or for negotiating a disputed claim. You will be responsible for paying any bill that your insurance denies.

FEE AGREEMENT

- I agree to pay the following fees:
  - Intake / Evaluation session (1 HOUR) $175
  - Individual session (45 minutes) $120
  - Individual, couples or family session (60 minutes) $150
  - Telephone call or consultation exceeding 5 minutes prorated $100/hr
  - Re-billing charge for all accounts carried over 60 days $5/month

- I understand that payment of my fee or co-payment is due and payable at the time of each counseling session unless otherwise arranged.
- I agree to pay the **full fee** as stated above for missed appointments or appointments canceled with less than 24 hours notice. In the case of groups, I agree to pay for all missed group sessions and understand that I am paying for my group membership even if I can't attend a session.
- I have read the Therapy Policies and Informed Consent Statement and understand that regardless of any insurance coverage I have, I am responsible for payment of my account. I agree that in the event costs and/or fees are incurred in the collections of my account; I will pay such costs and fees.

RELEASE OF INFORMATION

I have read the Therapy Policies and Informed Consent Statement, including the Fee Agreement and understand my financial responsibility. I authorize the release of my/our clinical record information to my/our insurance company for the purpose of billing, authorization of treatment, healthcare credentialing, utilization review and quality assurance review.

_____ _____

Signature Date

_____ _____

Signature of Parent, Guardian, or Legal Representative Date

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