CLIENT INFORMED CONSENT TO TREATMENT

The information presented below is important for you to read and understand. If you have any questions about this or any other form, please share them with your counselor. In order to receive services here you will need to sign this form, indicating that you have read and understand this information.

CONFIDENTIALITY

All information you share here is confidential. This means that nothing you share here, including your name and other identifying information, will be shared with anyone other than the staff of Allies in Change. A general exception to our confidentiality policy exists only when you have given written permission to have contact with a particular individual or organization (detailed below). Even then, only relevant information will be shared with that person or organization.

There are certain circumstances where even without your written permission we have to share information due to legal requirements. One such exception is if you report having been abusive to a juvenile or an elderly person we have to make a report to protective services. A second exception is if you indicate a serious intent to hurt yourself or another, we would do whatever necessary to keep someone safe. Third, if we are ordered to release information by the court we must comply with such an order. Finally, if you take legal action against Allies in Change or file a complaint with a licensing board we may need to reveal information in mounting a defense.
If you are participating in group counseling here, other group members are likely to learn personal information about you. We ask that you and all group members not share any personal information about other group members outside of the group—in terms of personal information, what is said in the group should stay in the group. However, we cannot guarantee that other group members will keep confidential information to themselves.
The use of recording or transmitting devices during therapy sessions, including tape recorders, cell phones, etc., are strictly prohibited, as they would undermine the confidentiality of our services.

RELEASE OF INFORMATION

In order to provide you with the highest quality of care, there may be times when we will need to talk with others about you—either to give information to and/or receive information from them. In such instances we will ask you to sign a release of information giving us permission to have contact with that particular person or organization. While you may always refuse such a request for a release of information, in some circumstances we may not be willing to work with you without a signed release if we feel that the lack of communication may significantly compromise the quality of our services to you.

FEES, INSURANCE AND PAYMENTS

Payment of fees is generally required at the time of service. If applicable, we will bill your health insurance and you will be responsible for your deductable and co-pay. Please be advised that actual payments by insurance companies may vary from the information we initially received about your benefits. You will be responsible for any balance not paid by insurance, even if it differs from what we were initially informed by the insurance company. If your insurance is out-of-network you are responsible for all fees not paid by your insurance company. **If you are currently covered by both a primary and secondary insurance plan** (including Medicaid/OHP or Medicare), <u>you are required to disclose the information for both plans prior to receiving services from Allies in Change</u>. If you do not disclose all of the necessary information to us, you may be responsible for all of the charges for the services you will receive.

Keep in mind that insurance will not cover missed appointment charges. Non-payment of fees is grounds for refusal to provide you with additional services until the outstanding balance has been paid. You are welcome to make arrangements to take a mutually agreed temporary leave of absence from the agency for financial reasons. Additional paperwork is required under this policy, conditions of which are specified within the Leave of Absence agreement. Cont.

If you've written a check and it is returned for non-sufficient funds you will be responsible for the original amount plus the bank fee of $40. This must be paid within two weeks.

EFFECTIVENESS OF COUNSELING
We consider all of our staff to be highly skilled and competent in their professional work. We will make every effort to help you successfully meet your stated therapeutic goals. Counseling involves a collaborative effort between you, the client, and your counselor. While each has their role, the bulk of the work will be done by you. It is important to note that there are no guarantees that you will meet your stated goals. While some clients have been quite successful in their work with us, others have only partially met their goals, not met their goals, or, on a rare occasion, have even gotten worse. Length of treatment can also vary greatly from just a few sessions to a few years or more. Evaluating progress in treatment and whether treatment goals are being met or should be modified should be an on-going process which you can raise at any time with your counselor.

ENDING INVOLVEMENT
You have the right to choose to end your involvement with this agency at any time that you wish. We would prefer that you discuss this with your counselor before choosing to do so. If you do not, then we ask that you at least notify us by phone or in writing that you will no longer be continuing with our services. Unless otherwise arranged, if we have not heard from you within a month since you were last in, we will assume that you will no longer be using our services and will close your case. You are always welcome to return in the future, if we can be of additional service.

More rarely, we may choose to end offering services to you. Typically this happens if you were to violate agency policies (e.g., disruptive behaviors to others, etc.) or we do not feel that our services are the most appropriate ones for you. In either case, we would always be willing to provide referrals to other agencies or individuals that you may find helpful, either in lieu of or in addition to your involvement with us.

PROBLEMS/COMPLAINTS
Occasionally, a problem may arise regarding your treatment with Allies in Change. Whether it is a procedural difficulty such as a billing question, or a question about the counseling you are receiving, we encourage you to first speak with your counselor about any concerns you may have. If that is not helpful or you feel uncomfortable talking with your counselor, we encourage you to speak with the counselor's supervisor. If your counselor is licensed you may also file a formal complaint with that counselor's licensing board.

EMERGENCIES
If you are in crisis or otherwise in need of immediate assistance you may attempt to talk with your counselor by contacting him or her at the agency phone number, and indicating that you are in need of an immediate response. Keep in mind that voicemail is rarely checked late in the evening or on the weekends. If you reach our voice mail or the counselor is not otherwise available, call the 24 hour mental health crisis line at (503) 988-4888.

MEDICATION
Allies in Change's therapists are not able to prescribe medication.

CANCELLATION POLICY
We ask that you give us at least 6 hours notice when needing to cancel or change an appointment. If you do not give such notice, you will generally be charged a no-show/late cancellation charge. You will not be charged for missing an appointment on short notice where it is unsafe to make it to the appointment (e.g., bad weather). If we need to cancel an appointment we will do everything we can to likewise give you more than 6 hours notice as well. Please note that the group attendance cancellation policy may differ from this. Please refer to additional information about the group policy with regards to attendance expectations.

AGREEMENT TO ABOVE CONDITIONS
I have read this informed consent and have asked questions about any parts that are unclear to me. I fully understand and agree to the conditions stated herein.

Signature:_____ Date:_____

Name (Printed):_____

Witness:_____Date:_____