

Leslie Rheault, LPC

916 West 10th • Suite 207 • Medford, OR 97501

Phone: (541) 499-1088 • Email: leslie@throughthewoodstherapy.us

INFORMED CONSENT STATEMENT

Treatment Philosophy

Welcome to my office! I look forward to our time working together. 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. An evaluation of your needs will help us to jointly develop a treatment plan in accordance with your goals. During our time together, you will be asked to work on various tasks/activities in between our sessions. Occasionally individuals may go through periods of increased stress in therapy which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. I cannot guarantee that treatment will be successful. If I determine that I cannot provide the treatment you need I will let you know as soon as possible and refer you to a provider I feel can offer you the treatment you need. I may also make other appropriate referrals if I find it necessary (i.e. psychiatric evaluation). Remember, you always retain the right to request changes in treatment or to refuse treatment at any time.

Managed Care

If your health insurance is a managed care plan, you may know that it involves cooperation between client, provider and insurance company to provide services as efficiently as possible. Your contract with your health insurance company states that your mental health coverage is limited to:

- Services that are determined to be “medically necessary”. Medically necessary may be defined as presentation of a covered DSM V Axis I diagnosis (these are acute symptoms).
- Conditions that are able to be treated by short-term, problem focused, goal oriented approaches whenever possible.

This means your insurance company will cover a limited number of office sessions to work on your problem as intensely as possible with the focus of eliminating acute symptoms. I may or may not be contracted with your insurance company to provide my services within these conditions. This practice reviews cases for quality assurance. Your case may be reviewed by a utilization review quality assurance group set up by the insurance company. I will maintain your confidentiality in this process.

Financial Policy

I require payment at the time of service. Although I do the billing for your insurance, I wish to stress that our contract for payment is with you, not your insurance carrier. Please understand that if there is a problem with payment from your insurance company, you will still be required to pay your bill to me. I will gladly discuss a monthly payment plan with you.

Divorce and Legal Proceedings

In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. Although I may provide therapy services for families, I am not a custody or visitation evaluator and will not make any recommendations or attend court hearings pertaining to those matters. Should I ever be subpoenaed, I will charge a professional consultation fee of \$250/per hour that is not billable through your insurance. Services such as chart reviews, phone calls, report writing, speaking to lawyers, attending and waiting for any court hearings, etc. will be part of this consultation fee. A four hour minimum deposit for my participation in court hearings is expected ten days prior to the court date.

In the event that you are coming in for treatment because you have been asked to obtain a psychological evaluation, it is important for you to know that therapy is not the same as an evaluation. I will refer you to the right provider who offers psychological evaluations.

Cancellations and Missed Appointments

My policy on appointment cancellations or missed appointments is as follows: If you must cancel or change an appointment, please give me 24 hours notice, except in case of an emergency. If you cancel giving less than 24 hours notice, or do not show up for a scheduled appointment, you will be charged 50% for the time reserved. A second no show or cancellation will be a charge of 100% for the time reserved. There will be no charge for cancellations due to illness or emergencies.

How To Reach Me and Emergency Contacts

You can leave messages for me on a confidential voicemail at (541) 499-1088. Your call will be returned promptly. If you or your child are experiencing a mental health emergency, call 9-1-1 or go to your local emergency room right away. You can also call the 24 hour Jackson County Mental Health crisis line at (541) 774-8201; or Josephine County Mental Health at (541) 474- 5365.

Confidentiality

I abide by the laws and ethical principles that govern privilege and confidentiality. I will not disclose any information to anyone, nor even the fact that I have seen you without your written permission by way of a signed release of information form. Confidentiality is also an important issue when children and adolescents are involved in treatment. The following are exceptions to these standards:

- It is legally required of me that I act so as to prevent physical harm to yourself or others when there is “clear and imminent” danger of that happening. If I find out that a client has specific intent to bring harm to himself, herself or to another person, or to commit an act of violence, it is my responsibility to protect you and others and inform other family members, potential victims and/or the authorities when necessary.
- I am legally required to report cases of ongoing child, elder and disabled abuse.
- If a crime has been committed.
- I may have to release clinical information regarding you to insurance carriers as required for payment or review of your claim.
- I may have to release your records when ordered to do so by court subpoena. I may have to give information about you without your permission if ordered to do so by the court. However, I will make an effort to contact you to discuss this with you beforehand and request a written release from you if I judge this to be in your best interest. If you oppose a release of information, a court may still order me to disclose information.
- On occasion, clinicians consult with colleagues about their work. If your case were ever discussed it would be confidential and without your name or identifying information.
- If an emergency medical situation came up and I needed to help you.

Waiver of confidentiality: you understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at my office may become a matter of public record.

Seclusion/Restraint and Non-discrimination Policy for Oregon Health Plan Members

As an Oregon Health Plan member, you shall be free from any form of seclusion or restraint while receiving outpatient mental health services. Additionally, you shall be free from discrimination based on race, color, national origin, religion, sex, sexual orientation, gender identity, marital status, age or disability. This is in compliance with Title VI of the Civil Rights Act of 1990 (as amended), Section 504 of the Rehabilitation Act of 1973, and Oregon Revised Statute Chapter 659A. If you believe you have been discriminated against, please contact the Oregon Health Authority: Call 1-844-882-7889, 711 TTY; OHA.PublicCivilRights@state.or.us; or Visit www.oregon.gov/OHA/OEI

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Electronic Communication Consent

Electronic communication via cell phone, text and email is potentially unsecure. Therefore, electronic communication cannot be guaranteed as confidential. If I choose to communicate with **Leslie Rheault, LPC/Through the Woods Therapy** via cell phone, text, and/or email I consent and understand that **Leslie Rheault, LPC/Through the Woods Therapy** is not responsible for information disclosed. Do not email or text if there is a psychiatric emergency as the message may not get to me in a timely fashion.

In regards to Social Media (i.e. Facebook, LinkedIn, Instagram), I do not accept friend requests from current or past clients. This is due to confidentiality, our respective privacy and our therapeutic relationship.

I have read and I understand the risk associated with electronic communication and I consent to the above terms.

Signature of consenting client and/or Parent, Guardian, or Legal Representative

Date

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CONSENT TO USE OR DISCLOSE CLINICAL INFORMATION

I AUTHORIZE **Leslie Rheault, LPC/Through the Woods Therapy**, to use and disclose the health and clinical information of _____ for the purposes of Treatment, Payment and Health Care Operations.

Name of client: _____

Treatment (includes activities performed by a practitioner, facility, program, nurse, office staff, and other types of healthcare professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers.

Payment (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for clinical necessity, justification of charges, precertification and preauthorization).

Health Care Operations (includes the necessary administrative and business functions of my practice).

You may review **Leslie Rheault, LPC/Through the Woods Therapy** “Notice of Privacy Practices” for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. **Please verify that you have received a copy of my NOTICE by placing your initials here:_____.**

Because I have reserved the right to change my privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in the lobby of my office indicating the effective date of the Notice in the upper right hand corner. I will offer you a copy of the Notice on your first visit to my office after the effective date of the then current Notice. I will also provide you with a copy of the Notice upon your request.

As more fully explained in the Notice, you have the right to request restrictions on how I use and disclose your protected health information for treatment, payment and health care operations purposes. I am not required to agree to your request. If I do agree, I am required to

comply with your request unless the information is needed to provide you emergency treatment.

I understand that I have the right to revoke this CONSENT provided that I do so in writing, except to the extent that **Leslie Rheault, LPC/Through the Woods Therapy**, has already used or disclosed the information in reliance on this CONSENT.

Client Name (Print)

Date of Birth

Client Signature

Date

Parent, Guardian or Legal Representative (Print)

Signature of Parent, Guardian, or Legal Representative

Date

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Coordination with your Primary Care Provider

If you receive your medical care from a Primary Care Provider (PCP), I would like to coordinate the care and services I deliver here with the care and services you receive from your PCP. If you agree with this approach I will notify your PCP that you have entered treatment with me. Please sign to authorize the release of your initial intake diagnosis and treatment plan.

I hereby authorize **Leslie Rheault, LPC/Through the Woods Therapy** to furnish/receive medical, psychiatric or psychological information from the records of:

Client Name: _____ DOB: _____

To/from: Name of PCP: _____

Phone: _____ Fax: _____

Address: _____

This release is effective from the date it is signed for the duration of treatment unless otherwise specified as follows: _____. I understand that the parties in receipt of these records may not further disclose the clinical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

Client Name (Print) Date of Birth

Client Signature Date

Parent, Guardian or Legal Representative (Print)

Signature of Parent, Guardian, or Legal Representative Date