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**Clinician-Client Agreement and Financial Responsibility**

**Please read and *sign two copies*. Keep one for your records**

Thank you for choosing Portland Therapy Solutions. This agreement outlines your rights, responsibilities, and financial and other logistical arrangements for the clinic. Please review it carefully and ask any questions you may have before signing.

**Rights and Risks:**

* You have the right to a respectful, professional, confidential relationship with your therapist. Please see Confidentiality” below for information about the limitations of confidentiality in therapy.
* You have the right to participate in developing your treatment plan, to understand any diagnosis, and to ask questions about any aspect of the therapy process.
* You have the right to limit what you share in therapy, although therapy will be most effective if you are open with your therapist, even about difficult topics. If you are court-ordered or required by an agency to participate in therapy, please talk with your therapist about the risks and benefits of discussing issues you would not want shared in a report to the court/agency.
* Talking about emotionally charged and distressing subjects is part of the therapy process, and may lead to stress or emotionality outside of the therapy session. This is normal; however, if you find that this is interfering with your life outside of therapy, please discuss this with your therapist.

**Confidentiality:**

* Information shared by you in session will be kept confidential.
* Information will not be released to an outside party or agency without your written consent.
* Our therapists regularly participate in professional consultation with other qualified health professionals both within and outside of Portland Therapy Solutions, LLC to ensure the highest quality of care is being provided. If consultation is sought with a professional outside this agency, no identifying information will be shared.
* Mental health professionals are required by law to disclose suspicion or report of child abuse or abuse of an elderly or disabled person. In Oregon, there is no time limit on this requirement, meaning that childhood abuse of an adult must be reported. If you have concerns about this, please talk to your therapist.
* The court may subpoena counseling records and/or testimony from your therapist. If you are involved in or anticipate being involved in legal proceedings, please discuss this with your therapist at the time of intake. Our therapists do not do custody evaluations and do not ordinarily provide custody recommendations in court cases.
* It is understood that information regarding treatment and diagnosis may be provided to an insurance company if you are using insurance to pay for mental health services.
* You may want to discuss further limits or exceptions of confidentiality.

**Therapy with Children/Adolescents**

* Teenagers 14 and older have most of the same rights as adults regarding confidentiality in therapy. We strive to work with parents and teens to make an agreement regarding confidentiality and what will and will not be shared with parents at the beginning of therapy and revisit this issue as needed throughout the therapy process. Teenagers fourteen and older must sign their own consent for treatment and agree to any release of confidential information as outlined above.
* Teens and children 13 and younger do not have the same legal rights to confidentiality as older teens and adults; these rights are held by their parents or legal guardians on their behalf. However, in most cases, especially with older children, it is beneficial to provide some amount of privacy in the therapy relationship. We will discuss this with children and parents at the beginning of therapy and revisit the issue as needed throughout the therapy process.
* Individual time spent in session with children (and younger teens) is often shorter than the usual length for adults (50 minutes); however, especially with younger children, consultation with parents (with or without the child present) may use some of the session time. The proportion of time spent individually with a child client versus with the parent and child varies by age and the child and family’s needs. Time spent with the parent and child is ordinarily billed as part of the child’s session.

**Family and Couples/Marital Therapy**

* In family therapy with families in which one or more family members are also seeing an individual therapy at Portland Therapy Solutions, LLC, an agreement regarding the confidentiality of individual sessions will need to be made. While individual family members have a right to confidentiality, the family has a right to know if major issues are being kept confidential by the therapist. We ordinarily will not agree to do family therapy in cases in which one party has shared a major issue (such as infidelity or substance abuse) with their therapist, but is not ready to disclose this to family members, and we may terminate family therapy if such an issue is disclosed while family therapy is ongoing.
* Family therapy is not normally a reimbursed service by insurers, unless the session is focused on the treatment of one family member’s diagnosed mental health issue. Please talk with your clinician about payment if family therapy is part of your treatment plan.

**Appointments:**

* Appointments should be made with your therapist at the time of the previous appointment. If this is not possible, please contact your therapist at the office line (503-995-4422) as soon as possible.
* Please arrive on time. Your therapist will need to end the session at the scheduled time even if you arrive late.
* Late cancellation (less than 24 hours before) *and/or* no-show appointments are billed to the client for the full amount. In the case of illness, please notify us no later than 9:00 a.m. the day of the appointment. Please leave a message if you get voice mail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies will not pay for no-show charges or late cancellation charges or for telephone consultations.

**Emergencies:**

* The **best phone number** for all therapists is **503-995-4422.** If you receive the voice mail, please leave a message identifying who your therapist is and what you are calling about. Your therapist may be on the phone, in therapy with someone else, or out of the office. We ordinarily check voicemail several times per day, so please be aware that it may be several hours before someone receives your voicemail. If your therapist is not available and it is an urgent matter, another clinician may return your call. In this case you may decide if you would like to consult with the other clinician or wait for your own therapist to become available.
* If you are experiencing a crisis situation, and your therapist cannot be reached, you may **call the 24-hour Multnomah County Mental Health Crisis Line:** 503.988.4888**. If you are experiencing a life-threatening emergency, pleasego immediately to your local hospital emergency room.**

**Fees:**

* Fees are expected to be paid at the time of service unless other arrangements have been made.
* Your health insurance may help you recover some of your counseling costs. Most group policies provide some coverage for outpatient psychotherapy. If your policy requires preauthorization to receive services, it is your responsibility and needs to be handled prior to your first visit.
* Insured clients are expected to pay copays as services are rendered. Our office will bill your insurance company for services provided if we are an in-network provider for your insurance company. You will receive a statement each month reflecting any balance due on your account. This office cannot accept responsibility for collecting your insurance claims or for negotiating a settlement on a disputed claim. You are responsible for payment (and insurance claims) on your account. *Insurance companies do not allow us to waive or permit sliding scale payment for co-pays.* If we are an out-of-network provider for your insurance company, you are responsible for paying the full amount of your fees at the time of service and seeking reimbursement from your insurer. We will provide you with documentation of diagnosis, type of service, and treatment plan as needed for your insurance reimbursement.
* Except in the case of minors or when other arrangements are made, the person receiving the counseling service is financially liable.
* Accounts become delinquent after thirty (30) days. ***Accounts 90 days in arrears will be terminated***.
* Any change in my financial situation I will discuss with my therapist.

I have read, understand and agree to the above policies. I consent to treatment for myself (or my minor child). I have been offered a copy of these policies to take with me if desired. I hereby authorize **Portland Therapy Solutions, LLC** and my therapist to release any information acquired in the course of my therapy to my insurance company (if client is a minor, parent or guardian sign). I understand my insurance coverage is a relationship between me and my insurance company, and I agree to accept financial responsibility for payment of charges incurred. I understand that a re-billing fee/financial charge complying with Oregon state law will be applied to any overdue balance, and in the event of non-payment, I will bear the cost of collection and/or court costs and reasonable legal fees should this be required. I have read and/or received a copy of **Portland Therapy Solution**’s Privacy Policy

**Initial Interview \_\_\_\_\_\_\_\_\_**

**Session Fee**  \_\_\_\_\_\_\_\_\_\_

**Non or Late Cancellation \_\_\_\_\_\_\_\_\_\_**

**Bounced Check Fee \_\_\_\_\_\_\_\_\_\_**

**Client(s) Signature(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client(s) Signature(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_