BRIDGEWAY
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THERAPY POLICIES & INFORMED CONSENT STATEMENT

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

PROFESSIONAL CREDENTIALS: I have a Master of Social Work degree and I am a Licensed Clinical Social Worker in the State of Oregon.

THERAPIST AVAILABILITY: Voice mail is available 24 hours a day to take messages. If your call is an emergency, please call 287-7006, press "0" at the prompt and an answering service operator will do their best to contact me quickly. When I am unavailable, another therapist will be covering for me. We do not text with clients.

CONFIDENTIALITY: Discussions occurring in psychotherapy are confidential. I will not discuss your case with anyone else without your written permission.

Legal exceptions to confidentiality include:

(1) when a client is a danger to themselves or others;
(2) when there is reason to believe that a minor, a developmentally disabled person, or an elderly person was a victim of a crime, neglect, or sexual/physical abuse;
(3) when ordered by a judge to release information;
(4) when necessary to pursue non-payment of your bill for services rendered;
(5) when a client initiates legal action or makes a complaint against the therapist.

When the client is a minor child, other conditions such as divorce proceedings, lawsuits, or other legal matters between the parents may affect confidentiality.

CLIENT'S RIGHTS & 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 work progresses. You always retain the right to request changes in treatment, to end treatment at any time, or request a referral to another therapist.

Clients who have not had a session in over 30 days (or within a mutually agreed upon time) will be considered inactive. It is best to have a final session before ending therapy in order to review and assess overall progress. Anyone wishing to return to active therapy can do so by contacting me.

HEALTH INSURANCE: If you are using a health insurance benefit to pay for these services, you need 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 that there is evidence of a diagnosable condition with acute symptoms. 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. Rarely, a utilization review/quality assurance group set by the insurance company or a peer consultation group may review your file. In such a situation, your name and identifying information will be kept confidential.

Health insurance may or may not cover all services provided. For example, insurance companies rarely reimburse for phone calls, hospital visits, court testifying (testifying, travel, waiting), extended collateral contacts, or reports/review of records. If these services are provided they will be billed to you at the usual and customary rate.

FEE AGREEMENT: I agree to pay the following fees:

Service	Fee
Initial Session (Diagnostic Interview)	$165 per session
Psychotherapy	$140 per session
Couples/Family therapy	$140 per session

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 cancelled with less than 24 hours notice.

CANCELLATIONS: When you make an appointment, please try to keep it. If you are unable to keep your scheduled appointment, please call and leave a message stating the reason you are cancelling. Cancellations need to be made at least 24 hours in advance or you will be charged for the reserved appointment time. Your health insurance will not pay for appointments you fail to keep. You will be personally responsible to pay out of pocket for the full session fee.

PAYMENT PLAN: (To be completed with your therapist)

( ) Payment of full fee at time of each appointment.
( ) Client's co-payment of $ / % _____ due at time of each appointment.
( ) Other _____
_____

RELEASE OF INFORMATION:

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)
I authorize release of any information necessary to process my insurance claim.

_____ (Signature)
I authorize payment of medical benefits directly to the providers of services.

I have read and understood the agreement, and agree to assume responsibility for the fees incurred in the provision of professional services.

CLIENT OR GUARDIAN:

1) _____ _____
Date

2) _____

3) _____ _____
Therapist