

Dora Parys, LCSW
Child, Family and Individual Counseling

1193 Pearl Street
Eugene, OR 97401

Statement of Informed Consent

This document describes some of the policies and procedures that I have developed as part of my psychotherapy practice. At the end of the document, you are asked to sign to indicate your understanding and agreement to counseling services under these conditions. Please read each point carefully, and be sure to ask about anything that may be unclear to you.

Professional Status

I have worked with adolescents and families since 1994 and in 2002 transitioned to work with families and individual adults, adolescents and children in health care settings. I hold a Master's Degree in Social Work and I am a Licensed Clinical Social Worker #L3758. As a Licensed Clinical Social Worker, I am allowed to practice psychotherapy with children, adolescents, adults and families as long as I comply with the regulations of the Oregon State Board of Clinical Social Workers and ethical guidelines from the National Association of Social Workers (of which I am a member).

Contact Information and Emergencies

My office hours are Mondays through Fridays from 10 am to 6 pm and appointments times vary based on individual needs. On occasion, you may find it necessary to contact me by phone outside of our regularly scheduled appointments. I may not be immediately available by phone, due to being involved in sessions with other clients and other professional and personal responsibilities. When I am not available, you can leave a confidential voicemail message at (541) 515-3325 or at (541) 343-1937 and press "0" for the operator to assist you if needed. I check my messages regularly and will do my best to return your message in a timely manner during business hours.

In event of an emergency, please leave me a message informing me of such but I recommend you also consider seeking more immediate assistance.

Community resources include:

*For Children and Adolescents:
Mental health Crisis Team 1-888-989-9990*

*For Adults:
White Bird Crisis Line 541-687-4000 or local emergency room. If needed, call 911.*

If I am on an extended leave, I will generally have a colleague provide back-up assistance for clients in need. In this event, I will provide you with the practitioner's name and number so you may contact them as needed.

Psychotherapy Risks and Benefits

Participation in psychotherapy has shown to significantly benefit people who undertake it for personal growth, symptom reduction, behavioral change, self-development, skill development, improvements in relationships, increased feelings of well being and reduction of feelings of distress, increased ability to cope stressful events, resolution of specific problems and the exploration of feelings of personal issues and concerns that influence daily life and relationships.

Psychotherapy does, however, carry some risks. Risks may include uncomfortable feelings which can result from the exploration of difficult or unpleasant aspects of past or current experiences or discomfort from attempts to stretch oneself by engaging in new behaviors, relational skills and coping strategies. For children and adolescents this may manifest in behavioral reactions. The most notable risk is a lack of positive impact on presenting concerns.

Best outcomes of psychotherapy are typically associated with the following:

- Consistent attendance, active effort in collaboration, both on your part as the client and my part as the therapist.
- A positive relationship between therapist and client. Therefore, if at any time you feel uncomfortable or dissatisfied with our relationship or work, it is important that we discuss this so that we can make the appropriate adjustments to our work together or, if needed, I can assist you with referral to another provider.

Appointments and Scheduling

After the initial appointment(s), which typically will last a total of 60-90 minutes, each appointment will be approximately 50-60 minutes in length. You will be responsible for letting me know at least 24 hours in advance of any cancellation for a scheduled appointment. There are no fees charged for sessions canceled in advance. However, you will be charged for sessions you do not attend and do not cancel in advance. If your fee is being paid by another payer, such as a community agency or an insurance company, they will not be billed for missed sessions and these fees will be solely your responsibility. On occasion, I will also have to cancel or reschedule appointments and I will attempt to contact you at least 24 hours in advance whenever possible.

Fees

Fees, including any co-payment or con-insurance, are due in full at the conclusion of each session, unless we specifically agree to other arrangements. Fee for the intake session is \$195.00 and fee for 50-60 minutes sessions is \$150.00. In addition, there may be charges for specialized assessments, written documents such as certain kind of letters, reports, treatment plans, case management services and/or telephone calls. I will inform you of these when applicable prior to provision of service.

(Initial here) _____ Agreement for private pay fee in the amount of _____

For those whose fees are being paid by another payer such as a community agency or insurance company, it is your responsibility to be apprized of whether your treatment or other recommended services will be authorized and reimbursed. Any unpaid fees are the responsibility of the client. Please be advised that if your account remains overdue for over 30 days from the date of services provided you may be charged additional fees. If you have questions about third party billing, or need some assistance, please discuss this with me. Please see attached *Consent for Third Party Billing* form for more information on issues related to third party payment.

Confidentiality

I will treat what you share with me in great care. Law protects confidentiality of all communications between a client and a therapist as well as documentation as records. Confidentiality guidelines are determined by Oregon State Law, federal HIPPA guidelines, and my professional social work ethics.

Oregon State asserts certain exceptions or limits to confidentiality for cases in which there is potential harm to the client or others.

- I am mandated by law to report any suspected abuse to a child and disabled or elderly adults.
- In situations in which I believe you represent a serious bodily harm to yourself or others, I may contact appropriate authorities or seek hospital treatment for you on your behalf.
- If there is legal involvement in your case, I may be court ordered to release records or to testify. In such cases, I will typically attempt to assert confidentiality, however, a judge may overrule this if he or she determines that this information is necessary. I strongly discourage the use of treatment with me to further legal goals such as custody evaluation or abuse investigation. The purpose of my services is to promote client's well-being. If you are seeking services for legal reasons, we should discuss whether a referral to another resource or provider instead or in addition to your work with me is appropriate.

At times, coordination of assessment or treatment with other professionals/providers or people important in your life may be beneficial to treatment. This would require exchange of relevant information. In such cases, I will discuss this with you. You should know that due to privacy laws I am required to obtain written permission from you before releasing any information about our work together. You have the right to refuse to give permission or revoke permission in writing at any time. *In general, sharing of information is done for the sole purpose of benefiting your treatment.*

I am required to keep a file of our work together for clinical record and treatment operations. All information about you will be under my supervision and in a locked file. Periodically, I will seek clinical consultation with practice colleagues. I attend two monthly peer consultation groups with other mental health practitioners. We routinely discuss cases and assist each other in providing quality services. Any identifying information is left out of these discussions, and again, great care is taken to ensure your confidentiality. All of my colleagues

are also bound by the same confidentiality procedures identified above and no written record or documentation is made of these meeting, although I may make a note of a consultation in your file if indicated.

Please refer to the attached privacy notice for more detail regarding federal confidentiality guidelines.

Please initial below to indicate that you received the **Notice of Privacy Practices**.

(Initial here) _____

Child and Adolescent Issues

Providing services to children and adolescents may present special challenges in relation to consent to treatment and confidentiality.

By Oregon Law, the custodial parent or guardian is the only person who can provide consent for treatment for children under the age of 14. Please note that a non-custodial parent is only legally able to provide consent for treatment in the case of emergencies when the custodial party is not available. Both custodial parents/guardians and non-custodial parents have the same rights regarding access to treatment information such as discussing treatment with me or reviewing treatment records directly pertaining to the identified client. This does not include access to information about others who may be referred to in the records during the course of treatment such as other parents, family members, etc.

It is always my goal to increase communication and connection between children/adolescents and their parents whenever possible. However, establishing a trusting relationship with a child/adolescent client may require that some information shared in therapy is kept confidential from parents. Please note, any information that includes threats of self-harm to a child/adolescent or others will be shared with parents except when to do so would put a child/adolescent in a harm's way. Always I encourage parents to share any information or concerns with me about their child/adolescent that would be helpful in understanding them or their treatment needs. Similarly, parents are always welcome and encouraged to share questions or concerns about the therapy process to promote discussion and shared decision-making.

Statement of Informed Consent

By signing this *Statement of Informed Consent*, I acknowledge that I have read the statement, agree to abide by its terms, and have had any questions or concerns about its contents addressed by Dora Parys, LCSW. Furthermore, my signature below indicates that I have voluntarily agreed to psychotherapy treatment for myself or my child/adolescent with Dora Parys, LCSW. I understand that, by law, I need not sign or enter into this agreement and I may choose to discontinue treatment at any time.

Client name (PLEASE PRINT)

Signature of Client or parent/legal guardian

Date

Client name (PLEASE PRINT)

Signature of Client or parent/legal guardian

Date

