NEUROHEALTH ASSOCIATES, LLP
OFFICE POLICIES & CONSENT TO TREATMENT

These office policies are provided for your information. Please ask us if you have any questions.

General Standards: As a psychologist licensed by the Oregon Board of Psychologist Examiners and as a member of the American Psychological Association we subscribe to the APA Revised Ethical Principles. A copy of the code of ethics is available for your inspection, if you would like to review it. After discussing and evaluating your need, we will develop a treatment plan focused on your goals for change. Occasionally, individuals go through periods in psychotherapy which result in emotional discomfort, changes in relationships, or temporary worsening of symptoms, It is often a sign of positive change and should subside as therapy progresses. Please discuss your thoughts, feelings, questions discomfort or concerns about therapy at any time when they arise. You always have the right to request changes or to end treatment.

Fees: Therapy services are billed at the rate of $160.00 per fifty minute appointment. Fees are due at the time of service, unless prior arrangements have been made. Longer or shorter sessions will be charged on a prorated basis. Telephone conversations which are longer than fifteen minutes will also be charged on a prorated basis.

Telephone Communication: The office telephone has a confidential voice mail system which may be reached at any time. Messages left during working hours usually will be responded to on the same day. If you need to reach your psychologist on an emergency basis, please call the office number, 503.221.7074 and speak with an answering service operator. Telephone conversations with the psychologist which are longer than 15 minutes, will be charged at the hourly fee on a prorated basis.

Billing: Client invoices are sent at the first of each month. Please pay the amount due within the next 30 days. A rebilling charge of 1.5% per month will be assessed to overdue accounts. Special billing arrangements may be made with clients who have insurance coverage. These must be set in advance of regular billing procedures.

Insurance Coverage: Please review your health insurance policy for full or partial coverage of outpatient psychotherapy provided by state licensed clinical psychologists. Our office will assist you in making inquiries about your coverage and will provide information needed to process your claim. We are providers for a number of health care insurers, however we cannot guarantee insurance coverage. **Therefore it is important to emphasize that you are responsible for the total amount of your bill, regardless of your insurance company's response.**

Delinquent Accounts: We reserve the right to submit delinquent accounts to our attorney or to a collection agency. When a delinquent account is referred to an attorney or a collection agency, the fact you have seen a psychologist is revealed necessarily and confidentiality cannot be protected.

Canceled or Missed Appointments: Sessions are arranged by appointment only. Scheduled appointments may be canceled or rescheduled by contacting our office directly. You may leave a telephone message about your cancellation at any time of the day or night. We will call you back to reschedule. There is no charge for appointments canceled more than 24 hours in advance. **Appointments canceled less than 24 hours in advance will be charged the usual hourly fee. Missed appointments (not canceled in advance) also will be charged at the full hourly rate.** Charges for late cancellations and missed appointments are billed directly to clients, not to insurance companies. Most insurance companies will not pay for these charges.

Confidentiality: We abide by all the laws and ethical principles that govern privilege and confidentiality. We will not disclose to anyone anything you tell me, nor even the fact that we have seen you in therapy without your written permission via a signed release of information form. The fact that you have come for services as well as **all issues** discussed during treatment or consultation are **strictly confidential**. State and/or Federal regulations permit the release of information only with the client's written consent. In the case of a minor (someone under 18 years old) a parent or legal guardian must provide this written consent. You should be aware that when you sign forms consenting to release all medical information about you for some purpose, We may be contacted to release your psychotherapy treatment records. There are a few exceptions to the confidentiality standards:

1. I am legally required to act so as to try to prevent physical harm to yourself or someone else, when there is "clear and imminent" danger of that happening.
2. I am required to report cases of ongoing child, elder or disabled person abuse.
3. I may be required to release attendance and diagnostic information about you in order to receive insurance payment for your treatment. I may be asked to release clinical information about you to your insurance carriers as required for payment or review of your claim. I will discuss this with you and obtain your written consent to do so.
4. Information necessary to process past due accounts will be given to an attorney or collections agency.
5. I may have to release your records if requested to do so by a court subpoena. I will discuss the details for privileged communication with you beforehand and request your written consent if you and I decide that releasing the information is in your interest.
6. I may use a fax machine to send treatment information to your insurance company, or others who request it, following your consent to release that information.
7. On occasion, I consult with my colleagues about my work. If I ever discuss your case, I will do so confidentially, without using your name or identifying information.
8. NeuroHealth clinical staff may review my records for quality assurance purposes.

Treatment: After evaluating your needs the psychologist will develop a plan for treatment with you conjointly. Remember that you maintain the right to request changes in treatment or to refuse treatment at any time. It is important to discuss any treatment concerns, discomfort or questions you may have with your therapist.

Your signature below indicates that you have read and understood both pages of this office policies statement and you have obtained a copy for future reference.

Consent: I hereby request and consent to treatment. I have been informed of the nature of the treatment, and I understand that I may revoke this consent at any time.

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Signature Date

______________________________ ______________________________
Parent or Guardian Date Witness Date
(if required)