Consent for Treatment

Confidentiality: Counseling is most effective when people feel they can talk openly in an environment that is private. I am committed to the confidentiality and privileged communications of all clients. I will not share your personal information unless you sign a release that gives me permission to talk with a specific party. However, the following limitations and exceptions exist:

1. You provide me with your consent to release information;
2. I have reason to believe that you are a danger to yourself or to someone else;
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person;
4. I am ordered by a court to disclose information; or
5. I need to release specific information to your insurance provider in order to receive payment for services

Additional billing and payment issues: Full payment for the session is the client's responsibility and is requested at the beginning of each session. If you have insurance, I can bill your insurance. If your insurance requires a co-payment amount, that amount should be paid at the beginning of each session. Any other payment agreements must be made and agreed to in advance.

Billing is contracted with PBS Services. All confidentiality and medical privacy laws apply to this contract. If you have questions about your balance or other billing questions, you may contact PBS at (541) 343-8122.

Cancellation: Your session is reserved for you. If you are unable to make your appointment, please notify me at least 24 hours in advance. Your insurance company cannot be billed for a missed appointment. You will be responsible for payment for the missed session in the absence of advanced notification.

Emergency Procedures: If there is an emergency and I cannot be reached, please contact your physician, the emergency room at the hospital nearest you, or the mental health crisis line at (503) 988-4888.

Additional Issues: I appreciate the time you have taken to read this. It is important to be aware that sometimes people experience emotional discomfort or changes in relationships as a result of working toward goals of treatment. Please discuss any concerns you notice so that we can work together to help you cope with these changes and create a more positive outcome. One of the most important rights you have as a client is that you are always free to ask questions and communicate concerns as they arise for you now or at any point during you or your child's treatment. Please feel free to let me know directly how I can be of assistance to you. I very much look forward to working with you.

Authorization for Treatment: I have read this form and have had the chance to discuss it with the therapist who is working with me. I understand the information stated, and I agree to participate in treatment under the conditions described. I give permission for Maggie Bortz, MA, LPC, to provide necessary treatment or to make an appropriate referral for me and/or my child and to release necessary information to bill the client's health insurance.

_____ _____

Printed Name of Client or Child Date

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Signature of Client or Parent/Legal Guardian Signature of Maggie Bortz, MA, LPC