Statement of Office Policies and Consent for Treatment

Philosophy and approach: My approach to working with children, teens, their families and individuals is practical, strategic, yet holistic. You may expect me to be a compassionate listener without judgment within a safe environment, to provide research informed services, while helping you reach your goals as quickly and effectively as possible. My approach to working with children, teens, individuals and families is to identify and call upon innate strengths to find solutions that will meet their needs. At times, we may decide together to include important others in our work, such as a school teacher, family member, partner, your physician or other mental health professionals. We will discuss together each step we take toward your goals.

Education and training: I hold an MA in Psychology from Marywood University, graduating 2005. My coursework emphasized lifespan development, the diagnosis and treatment of both children and adults, group dynamics and family therapy. I employ an eclectic approach which includes strategies derived from cognitive-behavioral, brief solution-focused and narrative therapies. I also frequently use collaborative problem solving in addressing conflict resolution, behavioral concerns and communication within families.

Treatment: Our initial appointment is 60-90 minutes in length, and 55-60 minutes thereafter. During this initial appointment I will gather thorough history about you and your family as well as learn about the concerns that are bringing you to therapy. We will also work together to determine treatment goals and how best to meet those goals.

It is important that you understand your commitment to the therapeutic process. While I use methods that research and experience have shown to be effective with most clients, therapy requires active, regular participation on your part. External factors such as events in your child's life or irregular attendance can interfere with therapeutic progress. Often painful feelings come up during times of exploration, reflection and growth and at times things may "feel worse before they feel better." Please discuss with me any concerns that you have regarding the therapeutic process.

Adults and Confidentiality: It is important that you know the high value I place on protecting your privacy and confidentiality. What we discuss in our sessions is confidential and protected by Federal and State confidentiality laws and by my professional code of ethics. **Except in cases mentioned below**, information will not be discussed or released to anyone without your written consent. I believe that collaborating with other medical providers and previous treatment providers is an important part of your treatment, however, it is your choice whether or not to give permission to do so. **This confidentiality has exceptions when information may be shared without your permission and include:**

1. situations where child or elder abuse is suspected;
2. situations or threats of potential harm to self or others;
3. instances when I am subpoenaed to testify in court; and,
4. instances when a therapist is defending against a lawsuit or complaint.

Minors and Confidentiality: What we discuss regarding your child, and what your child discusses, in our sessions is confidential and protected by Federal and State confidentiality laws and by my professional code of ethics. As a parent of a client rather than a client yourself, what you tell me may or may not be covered under your child's confidentiality. **Except in cases mentioned below,**

information will not be discussed or released to anyone without your written consent. I believe that collaborating with other medical providers, family members, school personnel, etc. is an important part of your child's treatment; however, it is your choice whether or not to give permission to do so. **This confidentiality has exceptions when information may be shared without your permission and include:**

1. situations where child or elder abuse is suspected;
2. situations or threats of potential harm to self or others;
3. instances when I am subpoenaed to testify in court;
4. instances when a therapist is defending against a lawsuit or complaint;
5. instances when a non-custodial parent requests information; and
6. if I suspect your child's welfare appears to be in imminent danger.

Teenagers and Parents of Teenagers: There may be times when you have disclosed something to me that I consider to be high risk behavior (e.g., sexual misconduct, alcohol/drug abuse, and self-injurious behaviors). In other words, it may not be creating imminent risk of harm to you or someone else, but could lead to self-harm, adjudication, health problems, etc. I reserve the right, in those instances, to use my clinical discretion as to whether or not to report such behavior to teenage parents. I will always discuss this with my teenage clients and what warrants disclosure.

Parents of minors: My clients who are under 14 years of age and are not emancipated should be aware that the law allows parents (both custodial and non-custodial) to examine treatment records. Parents who do not have custody or the legal right to consent to medical treatment for their child will need written permission from the custodial parent prior to our initial appointment. At times, I may request a copy of the divorce decree to verify custody arrangements. In situations where I am providing services to a child of parents who are separated, I may recommend that both parents participate in the treatment.

Court Testimony: It is important for you to know that I do not wish to be party to any legal proceedings against current or former clients, or their parents. My goal is to support my clients to achieve therapy goals – not to address legal issues that require an adversarial approach. Clients entering treatment are **agreeing to not involve me in legal/court proceedings** or attempt to obtain records of treatment for legal/court proceedings when marital or family therapy has been unsuccessful at resolving disputes. This prevents misuse of your treatment for legal objectives.

If you are involved in or anticipate being involved in legal or court proceedings, please notify me as soon as possible. It is important for me to understand how, if at all, your involvement in these proceedings might affect our work together. Also, entering into treatment for therapy is not the same as a psychological evaluation or custody evaluation. In the event that you need an evaluation, I will be happy to assist you to find a provider that offers this service.

In the event that I am subpoenaed, I will make every attempt to protect your confidentiality, but, as stated above, please know that there may be limitations. Also, please note that I will charge for my testimony, including wait time, travel time, copies of records, and preparation/consultation time. I will charge at my highest customary fee, which is $160/hour, and you will be responsible for this fee.

Fees and Insurance information: My fee is $205 for the initial appointment; and, for appointments thereafter, my fee is $160 for both family and individual therapy. **It is your responsibility to pay any payments prior to every session.** Payments may be received by check, cash, or credit/debit card,

made payable to **Heidi M. Perez, M.A., LLC**. Brief phone calls with clients or on behalf of clients will not be charged for, unless a call with a client exceeds 15 minutes. If so, I may charge a portion of my standard fee. If at some point in our work together you experience financial difficulties, please let me know so we can discuss my financial hardship policies and create a payment plan.

I work with most insurance companies on either an in-network or out-of-network basis. Prior to our initial appointment my billing service will call your insurance company to verify benefits. If my services are covered, then my billing service will follow through with billing and collecting from your insurance company. I am obligated by contract with your insurance company to collect all co-pays, coinsurance payments or deductibles not covered in your plan. If you use your insurance, then I must send the insurance company a psychiatric diagnosis and often other information they require for authorization.

I highly recommend that you also check your benefits and be familiar with your coverage, limits, deductibles and co-pays. Although my billing service and I will do everything we can to collect payment from your insurance company, **you are ultimately responsible** for payment for any services that have been provided to you or your child. I will not attempt to keep track of your deductibles or benefit limitations.

Appointments and Cancellations: An appointment reserves a specific time for you. Missed appointments or cancellations **with less than 24 hours** of notice are subject to my full fee of $160. I allow for one missed or late cancelled appointment with no charge. **ALL** other missed appointments or late cancellations will be billed at my full fee; and the fee must be paid prior to rescheduling our next appointment. Please note that insurance companies **cannot** be billed for missed or late cancelled appointments. You will be responsible for the cancellation fee at our next session.

Contact Information and Emergency Procedure: You may leave me a message on my confidential voicemail at (503) 653-5205. Always leave a phone number where you can be reached and good times to return your call. I check my messages regularly Monday through Friday. I will make every effort to return your call as soon as possible.

Email may be used to communicate with me about scheduling. However, it is not guaranteed to be secure form of communication and **is not to be used for correspondence regarding crisis or emergencies.**

If there is a life threatening emergency, call 911 or go to the nearest emergency room. If there is an urgent clinical matter that needs my attention, but you can wait for my return call, which may take some time, please follow the instructions on my voicemail in order to do so. If you feel your urgent call has not been returned as quickly as you require, call the **Crisis Line in Multnomah County at (503) 988-4888 or in Clackamas County at (503) 655-8401, call 911 or go to the nearest emergency room.**

As a Professional Licensed Psychologist Associate: I abide by the Oregon Board's Code of Ethics. To maintain my license, I am required to participate in continuing education relevant to the work I do with clients. I also voluntarily participate in consultation with other mental health professionals. These consultations are bound by the rules of confidentiality and client names/identities are not disclosed.

As a client of an Oregon licensee, you have the following rights:

1) To expect that I have met the qualifications of training and experience as required by state law
2) To examine public records maintained by the Board and to have the Board confirm my credentials
3) To obtain a copy of the Code of Ethics
4) To report complaints to the Board
5) To be informed of the cost of professional services before receiving them
6) To be assured of privacy and confidentiality as defined by rule and law; see above
7) To be free from discrimination on the basis of race, religion, gender or any other unlawful category while receiving services.

If you have any questions or concerns either about this disclosure or about services that I have provided, please don't hesitate to discuss directly with me. You may also contact the Oregon Board of Psychologist Examiners: 3218 Pringle Rd SE, Ste. 130, Salem, OR 97302-6309; (503) 378-4154.

Agreement and Informed Consent:

My signature below indicates that I have been informed of, understand and agree to the above information regarding, treatment and confidentiality, fees and insurance, appointments, cancellation and emergency policies. I agree that I have had the opportunity to discuss the potential benefits and risks of therapy done by Heidi M. Perez, M.A., LLC. This consent can be revoked any time in writing. I am giving my informed consent for myself and/or a minor child or legal dependent to begin treatment.

Name of Client:_____

Signature of Client or Legal Guardian:_____

Date:_____

I acknowledge that I have received a copy of the privacy notice detailing HIPAA regulations. I have had an opportunity to discuss concerns and questions I have about the privacy of health information.

Name of Client:_____

Signature of Client or Legal Guardian:_____

Date:_____

I give permission to Heidi M. Perez, M.A., LLC to release relevant information about services provided to me and my child to my health insurance company. This information may include: diagnosis, treatment plan, symptom status, treatment compliance, response to treatment, and progress toward any treatment goals.

Name of Client:_____

Signature of Client or Legal Guardian:_____

Date:_____

I give my permission to Potpourri Business Services, Inc. to bill my insurance company for the purpose of collecting for services rendered with Heidi M. Perez, M.A., LLC. For billing purposes, please indicate below the person(s) we may contact on your behalf and their relationship to you, in case it is necessary to discuss insurance and/or payment.

Name of Client:_____

Signature of Client or Legal Guardian:_____

Date:_____

Other people we may contact regarding billing information:

_____	_____
Name	Relationship
_____	_____
Name	Relationship

Date:_____

To the best of my knowledge, all insurance information has been provided and is accurate. I authorize release of any medical information needed to process this claim. I hereby authorize payment of medical benefits to Heidi M. Perez, MA, LLC. I also authorize Heidi Perez to represent me, if needed, before the Oregon Insurance Commissioner.

_____	_____	_____
Responsible Party's Signature	Patient's Signature	Date