INFORMED CONSENT STATEMENT

Annie Dolle, LCSW: I am a Licensed Clinical Social worker in private practice. I have earned a Masters degree in Social Work and have been a Licensed Clinical Social Worker in Oregon since 2012. I adhere to the National Association of Social Workers Code of Ethics. The following information answers some important and frequently asked questions concerning my practice. Please read this form carefully and let me know if you need more Information about policies or treatment.

Confidentiality/Client Rights: I abide by the laws and ethical principles that govern privilege and confidentiality. I will not discuss any information about you with anyone without your written permission by way of a signed Authorization to Disclose Medical Records. There are some exceptions to this standard which are also noted in the Notice of Privacy Practices:

- I am legally required to act so as to prevent physical harm to yourself or others when there is “clear and imminent” danger of that happening.
- I am legally required to report cases of ongoing child, elder and disabled person abuse.
- I may have to release clinical information regarding you to your insurance carrier as required for authorization, payment of your claim, or quality assurance review.
- I may have to release your records when ordered to do so by court subpoena. However, I will discuss this with you beforehand and request a written release of information from you.
- I may consult with colleagues about my work. This is kept confidential, without using your name or identifying information.

It is important that you discuss any question or concerns that you may have now or in the future regarding exceptions to confidentiality.

Appointments and Fees: I provide psychotherapy to adults and adolescents. The fee is $130 per 50 minute session Ninety minute sessions are $160. Your co-payment is due at the time of service unless other arrangements are made in advance (or full payment, if insurance is not used or your deductible is not satisfied). There is a full charge for appointments canceled less than 24 hours in advance. Payment for late, canceled, or missed appointments will be due prior to the next appointment. For clients who have insurance coverage, claims are submitted on a regular basis unless you request otherwise. In the event your insurance does not pay for your treatment, you will be responsible for payment.

Legal/Court Involvement: If you enter into treatment with me, you are agreeing not to involve me in legal/court proceedings or to attempt to obtain records of treatment for legal proceedings.

Treatment Philosophy: Psychotherapy has both benefits and risks. It requires an investment of time and energy to make the most of the process. Sometimes clients go through periods in therapy which result in emotional discomfort, changes in relationships, or temporary worsening of symptoms. This should subside as our work together progresses. You will always retain the right to withdraw consent for treatment or refuse treatment at any time.

Contacting Me: When I am unavailable to take your call, my telephone is answered by a confidential voicemail that I monitor frequently. I promise to get back with you within 24 business hours. Let me know some times that may be best to reach you when you leave your voice mail.

Emergencies: Because you may not be able to reach me immediately during a mental health crisis, please contact Multnomah Mental Health Crisis Line at 503-988-4888, go to Unity Center for Behavioral Health, or to your nearest emergency department in these situations.

Grievance Procedure: If at any time you are dissatisfied with your care, please discuss your concerns with me directly so we can work together to resolve them. If we are unable to resolve your concerns, I will be available to assist in making an appropriate referral to a community partner. If you ever have serious concerns that are not resolved successfully with me directly, you may call the Oregon Board of Clinical Social Workers.

Consent to Treatment: Signature(s) below indicate that I /we have read and understand the above consent to treatment with Annie Dolle, LCSW, under the conditions specified above. I/we specifically authorize the release of my clinical record information for coordination with my insurance company for the purpose of payment, health care credentialing, utilization review and quality assurance review. In the event that treatment is for a minor child, I hereby give my consent to treatment and affirm that I am their legal guardian with authority to authorize mental health treatment.

Client Name (Please Print)____

Signature (Client or Legal Guardian)____________________________________Date___

Signature (Client or Legal Guardian)____________________________________Date___

Acceptance of Financial Responsibility: I assume financial responsibility for any balance on my account owed to Arrival Counseling LLC. I will make co-payments and pay amounts owed toward my deductible at the time of each session unless alternative arrangements have been made. I understand and agree to pay full fee for appointments canceled less than 24 hours in advance.

Client Name (Please Print)____

Signature____

Date _________