Paula Helsby, LPC
Individual, Couples and Family Counselor
103 South First St. Suite 200, Silverton, OR 97013 503-873-3608
117 NE 3rd Ave, Canby, OR 97013 503-263-5599
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Consent for Treatment

PLEASE INITIAL ALL

_____ **Consent to Receive Services**: I hereby consent to receive services from Paula Helsby, LPC. I understand that I may discontinue services whenever I choose.

_____ **Client Rights and Responsibilities:** I acknowledge that I have been informed of my rights and responsibilities as a client and have received a copy of the Client Rights and Responsibilities.

_____ **Notice of privacy practices:** I acknowledge that I have received a copy of the Noice of Privacy Practices.

_____ **Assignment of Benefits and Release of Information:** I hereby authorize the release of any medical, mental health, alcohol and drug, or other relevant information necessary to secure payment for claims filed on my behalf by from the first date of service until all services have been paid for after the end of my treatment. I authorize payment of mental health for services received. I acknowledge that any balance not covered by or paid by my insurance is my legal responsibility. I agree to notify Paula Helsby, LPC immediately of nay changes in my insurance.

_____ **Acknowledgement of Responsibility to Pay Charges**: I understand that I am expected to pay for the services I receive bases n the standard fee schedule. All clients are required to pay Copayments, deductibles, and non-covered services at the time of your visit. If you do not have insurance, you will be asked to pay for your services, in full, at the time of your visit. I realize I can pay via cash, check, visa, Mastercard, or Discover.

I understand that if I have insurance, which is available to pay for my treatment, that my insurance will also be billed fo the full cost of all services. I understand that insurance payments, if any, may not reduce that cost which is billed to me. Additionally, if I fail to provide necessary information for billing available insurance, I will be changed the fullest for services I receive.

If an insurance authorization has not been obtained or has been denied by my insurance, I will be responsible to pay the balance beyond my co-payments established by my insurance company.

I understand my health insurance may not cover some or all of the services provided by Paula Helsby, LPC. I agree it is my responsibility to understand my insurance coverage.

Late and/or No Show charges: Appointments not cancelled with a minimum of 24 hours notice (the day before by noon) will be charged $60.00 as well as No Show's. This charge is billed to the client and will not be billed to the insurance. The No Show and/or Late payment is expected before and/or at the next counseling appointment. The payment can be mailed my check to: Paula Helsby, P. O. Box 1001, Silverton, OR 97381 and/or by credit/debit card on my website: www. counselingbypaula.com.

If there is an unusual financial situation which causes payment of your account to be difficult, please discuss this with me to that we can make special payment arrangements.

I have read this payment policy and understand that regardless of any insurance coverage I my have, I am responsible for payment of my account.

_____

Signature (client, guardian, or Person Authorized to Sign for client)

Name (Please Print) _____

Date_____

Informed Consent

Thank you for choosing Paula Helsby, LPC. Today's appointment will take approximately 50-55 minutes. I realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of my policies, State and Federal Laws and your rights. If you have other questions or concerns please ask and I will try my best to give you all the information you need. Paula Helsby, MS, NCC, LPC has earned a Bachelor of Science Degree in Administration of Justice in Corrections from Portland State University and a Masters Degree in Counseling from Oregon State University and Western Oregon State College joint counseling program. She also has Masters in Theology and in Sacred Scripture from Mt. Angel Seminary. She has over 33 years of clinical experience in treating adolescents, adults and families. Paula practices gestalt therapy for most conditions as well as other therapies depending on the situation.

Confidentiality And Emergency Situations: Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information and/or your adolescent/teenage report about physical or sexual abuse; then, by Oregon State Law, I am obligated to report this to Department of Human Services, d) where you sign a release of information to have specific information shared and e) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law.

In the unlikely event that I am unable to provide ongoing services Bruce Makowski, LMFT will provide those services and will maintain your records for a period of 7 years. Bruce Makowski maybe contacted at 503-789-2120. If an emergency situation for which the client or their guardian feel immediate attention is necessary, please contact the emergency services in the community (911) or local emergency hospital room for those services. Paula Helsby will follow those emergency services with standard counseling and support to the client or the client's family. E-mail, text messages and social networking sites are not confidential and I may not be able to respond.

Signature(s)_____Date_____

Financial / Insurance Issues: I will bill your insurance company, responsible party or third party payer for you. I ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, I request that you pay the balance at that time.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice which is at noon the day before your appointment otherwise you will be charged $60.00.

Signature_____Date_____

Coordination of Treatment: It is important that all health care providers work together. As such I would like your permission to communicate with your primary care physician. Your consent invalid for one year. If you prefer to decline consent no information will be shared. This authorization maybe revoked at anytime.

_____You may form my physician ____ I decline to inform my physician

Physician Name:_____

Clinic:_____

Address:_____

Signature:_____Date_____

Notice of Privacy Practices and Client Rights: I/We have read and received a copy of the, Notice of Privacy Practices and Client Rights document. May I contact you at home (circle one) Yes, No? May I contact you at work Yes, No? May I contact you by cell phone Yes No. Where may we contact you?

_____

Signature(s)_____Date_____

Consent For Treatment of children and Adolescents:

I/We consent that _____ be treated as a client with Paula Helsby, LPC. It is understood that children over the age of 12 have confidentiality protected by law. At times it may be necessary to schedule appointments during school hours. I ask for your cooperation to provide the most timely treatment for you and your children. This consent to treat expired at the end of treatment or if revoked in writing.

Signature(s)_____Date_____

Client Rights and Responsibilities

This is a list of your rights and responsibilities when receiving services. Please read it carefully. Please use your rights and responsibilities.

Your Rights:

1. You have the right to be treated with dignity and respect.
2. You have the right to be told of: Treatment options, Consequences of Treatment, Your diagnosis, Covered and non-covered services, and Your right to refuse services.

3. You have the right to receive services without discrimination because of race, color, creed, religion, sex, national origin, sexual preference, handicap, age.

4. You have the right to get the services you need.

5. You have the right to be protected. If you or anyone you work with thinks you are being abused, you have the right to an investigation and a safe place to stay during the investigation, even if the person hurting you is a member of your family. The State of Oregon defense abuse as: Any injury that is not accidental, or that you can't explain, when someone hurts you on purpose, when someone makes sexual comments or acts sexual with you and you do not like it.

6. You have the right to be told how much it will cost to come here. You have to agree to pay me before I can charge you any money.

7. You have the right to have a friend, family member, or advocate with you at your appointments if appropriate for you care.

8. You have the right to receive care that serves your needs.

9. You have there right to receive an appropriate assessment.

10. You have the right to file a complaint if your are unhappy with the services you get here and you will not be treated differently without an explanation.

11. Confidentiality. I won't talk to people about you or show them your record unless you say it is Okay in writing. There are some limits to that. Sometimes I have to talk to people about you even if you say it is not Okay. Those times are:

If you have an emergency, if I think you might be abused, if I think you might hurt yourself or someone else; if you have told me you have committed or may commit a crime, if a judge tells me I have to.

12. You have the right to receive, and have explained to you, written information about:
Rights and Responsibilities.
Benefits available
Fees charged you, if any
What to do in an emergency; and
How to make a complaint or file a grievance.

Your Responsibilities:

1. You have the responsibility to agree to be seen by me.
2. You have the responsibility to tell me when you do not understand or cannot follow instructions.
3. You have the responsibility to ask questions until you clearly understand the information.
4. You have the responsibility to work on your goals.
5. You have the responsibility to keep information about other people confidential
6. You have the responsibility to keep appointments. Call me the day before you appointment by NOON if you are going to miss your appointment.
7. You have the responsibility to pay for your services.
8. You have the responsibility to work out problems with me if you have them.

Emergency/Urgent Services:

My office number is (503) 873-3608 in Silverton and (503)263-5599 in Canby. I do not provide crisis services. I may consult over the phone briefly in a time of crises and may bill clients directly for this time. I check my email and voicemail regularly during office hours and after hours and will attempt to return all emails/calls within 24 hours. If I am on vacation there will be information provided regarding coverage.

In case of an emergency:
1. Go to nearest emergency room or call 911.
2. Clackamas County Crisis line 503-655-8401
3. Psychiatric Crisis Center in Marion County. Walk in 24/7 503-585-4949

Office Procedures

Description of therapy sessions

Individual, couples and family therapy sessions are scheduled for 50-55 minutes unless otherwise indicated.

I do not do counseling for those who want to use counseling for the purpose of getting Disability or for custody for children and teenagers.

Fees and Payments

$140.00 Initial Session
$90.00 50-55 Minutes Sessions

If you do not have insurance coverage and are not able to pay my fees because of financial burdens, I may reduce your fee.

Method of payment accepted are cash, credit card and check. Payment at time of service required. You are responsible for your insurance co-pay and your full bill if insurance refuses to pay.

I take many forms of insurance. You are always responsible for your co-pay or the cost of the session if insurance does not pay the full amount. Please call your insurance for your co-pay.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $250.00 per hour for preparation and attendance at any legal proceeding.

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 proceeding might affect our work together. It is also important for you to know that I will not be a party to any legal proceedings involving current or former clients. My goal is to support my client 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 record to treatment for legal objectives.

Couples Therapy

If you and your partner/spouse decide to have some individual sessions as part of the couples therapy, what you say in those individual sessions will be considered to be a part of the couples therapy, and can and probably will be discussed in our joint sessions. Do not tell me anything you wish kept secret from your partner. I will remind you of this policy before beginning such individual sessions.

Cancellation Policy

There are many reasons to cancel an appointment. **You must call the day before your appointment by NOON or I will charge $60.00 for late cancelation/no show. Please call 503-873-3608 or 503-263-5599 to cancel and to make appointments.**
The only exception where I will not charge you if it is a weather event or natural disaster.

Communication

My business phone number is 503-873-3608 or 503-263-5599. For non-urgent matters I will get back to you as soon as possible, usually within one to two hours and less frequently on the weekends. There is no charge for brief telephone calls lasting between 5-10 minutes. Calls of 15 minutes in length or longer will be changed proportionally at my hourly rate of $90.00.

Electronic Communication

Emails will only be used for scheduling and not for personal counseling or conversation. I check and respond to email usually twice per day, typically between 8-8:30am and in the afternoon. If you need me to respond more quickly, please call and leave a voicemail message.

If you are cancelling an appointment please call 503-873-3608 or 503-263-5599. I prefer you call me then email for cancelling an appointment.

Email has significant limitations and confidentiality cannot be guaranteed. It is important to be aware that computers, unencrypted email and texts can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication.

Emails, texts, and e-faxes, in particular, are vulnerable to such unauthorized assess due to the fact that servers or communication companies my have unlimited and direct access to all emails, texts and e-faxes that go through them. If you communicate confidential or private information via unencrypted email or tests, I will assume that you have made an informed decision and will view it as your agreement to take the risk that such communication my be intercepted, and I will honor your desire to communicate on such matters.

If you are using your insurance, please fill out this information.

Insurance verification:

Client's name_____DOB_____

Insurance Company_____

Mental Health Outpatient Company _____

Number to verify benefits_____

Primary Insured_____

Employer_____

I.D. #_____

Policy #_____

Group #_____

Birth Date_____

Claims Sent to:

Your Signature_____Date_____