Heather Nielsen, MA, LPC
Licensed Professional Counselor
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Informed Consent for Counseling and Consent to Treatment

Nature of the Treatment Provided:

Counseling and Coaching Therapies

We create a team to facilitate growth and well-being – relief from current suffering, and movement towards thriving. The client is an active participant in the therapy and change process. My strengths- based approach employs experiential and creative therapies as well as insight-based, mindfulness-based, body-based, and cognitive-behavioral interventions to promote expanded self-awareness and genuine self-compassion. Through the lens of a positive focused system along with visioning, goal-setting, and problem solving skills, clients expand their abilities, gain new perspectives and engage in their positive growth and healing.

Licensure

I am currently licensed as a Professional Counselor in Oregon **LPC # C3397**

Certifications

I have been a Certified Health and Wellness Coach, certified through Wellcoaches, since 2012.

Professional Associations

American Counseling Association
American Diabetes Association
Wellcoaches Member-in-Practice

Ethical Guidelines

I follow the ethical guidelines set out by Oregon State licensing board, the American Counselors Association and National Board of Certified Counselors.

Disputes and Complaints

Bring concerns to my attention for discussion and resolution before taking further action *if possible*.

Risks and Benefits of treatment

The counseling and change process in general can involve new perspectives, emotional experiences and changes in behaviors, and even though the intent is client growth, the process itself can be challenging. An option for no treatment can be an alternative to counseling and might bring with it risks by doing nothing to address or accelerate an opportunity to change.

Alternatives to treatment

Might include a medical evaluation, counseling from a different theoretical perspective, talking with trusted family and friends, participating in self-help groups, utilizing body based therapies, exercise and nutrition.

Competence and Lack of Coercion

All clients included in the therapy dynamic have a right to clearly understand informed consent, be competent to make a decision free from undue coercion to agree to therapy.

Right to Refuse or Discontinue

Any client has a right to refuse or discontinue treatment at anytime without penalty. If needed a referral will be provided.

Confidentiality and Limits to Confidentiality

- These following conditions are defined by Oregon Law:
- Reporting suspected child abuse
- Reporting Elder abuse
- Reporting imminent danger to self or others
- Reporting information required in court proceedings
- **As requested by client's insurance company for billing purposes**
- Providing general information for therapist case consultation or supervision
- Defending claims brought by client against therapist that are either reported to the Oregon Board of Licensed Professional Counselors and Therapist or in a legal proceeding.

Cancellation Policy

I respectfully request 24 hour notice for cancellation of an appointment. In the need that I request a cancellation or change, I will also do my best to notify you 24 hours or more in advance. **With less than 24 hour notice, unless due to illness or emergency, I will charge a fee of $50 which is not payable/billable to insurance.**

Thank you for your consideration in this important matter.

____

Signature acknowledging cancellation policy

Privacy of Client information

All client counseling records and notes have both an electronic element in a secure, online system (CounSol.com secure portal), and are also kept in hard copy in a locked file cabinet in my locked counseling office.

If you sign the waiver to allow electronic communications, you are aware of the vulnerability of this communication and information.

Client Referral

If therapy progresses to areas that fall outside my area of expertise which cannot be fulfilled through consultation or supervision it is appropriate for me to discuss with you/ the client the need for a possible referral to a clinician or program who specializes in that area. Threats or harassment made by client to counselor where counselor feels unsafe and unable to be unbiased in delivery of treatment in best interest of client would warrant referral and possible immediate termination, depending on severity of harassment.

Termination of Services: Services are formally terminated/ended under anyone of the following events:

1. Mutual agreement between counselor and client(s).
2. Client's request to end services.
3. *Necessity of making a referral as appropriate for best client care.*
4. *Threats or harassment made by client to counselor where counselor feels unsafe and unable to be unbiased in delivery of treatment in best interest of client.*
5. If client(s) has/have not been seen for 45 days or client(s) have not contacted the counselor for an appointment for 45 days ***or*** has missed 2 scheduled appointments without explanation.

Clients may reopen services at any time except under item 4.

Sign & Date:____

Requests Related to Legal Proceedings:

As part of my professional practice **I do not** testify in court about couple or family matters including custody issues related to minors. I am not trained as a court expert witness and request you let me know if there are legal issues involved. I would refer you to your legal team that can identify the best plan of action and select a professional trained as an expert witness to support your situation.

Request for Records:

If a client requests records, 15 business days are required to prepare. I provide a summative letter of clinical services provided or summative notes for each session upon discussion with client. The fee for this service is $120.00 per 50 minute hour, which may be billed in 25 minute increments.

<u>Office Hours, Contact and Communication Information</u>

Appointments

Please phone **971-263-6169,** leave a message and I will return your call as quickly as possible. You may also set your own appointment via CounSol.com or by email.

Phone Calls

I am available to return calls **Monday through Friday 9:00 a.m. to 5:00 p.m.** related to needs like rescheduling, cancellations, questions or general information and if you leave a message I will return your call as soon as possible. ***If you have an emergency outside my office hours or I can't be immediately reached please call Multnomah County Triage Center 503-988-4888, go to your local emergency room or call 911.***

E-mails

All e-mails become part of the client and/or family official counseling records. E-mails should ideally be used for brief necessary communications. **<u>I acknowledge that any email is not a totally secure technology in general and there is a possibility that client information could be revealed without the intent of the client or clinician</u>**. I do offer Secure E-Mail through CounSol.com.

Texting

Texting is for the purpose of confirming appointments, late arrival, need to reschedule as well as requests to contact.

Consent for Transmission of Protected Health Information by Non-Secure Means:

If you would like to consent to transmit protected health information by non-secure methods, with full awareness that the following forms of communication are not guaranteed secure: Texting, Email, and any other electronic communication, please sign below:

____ ____________
Signature of client Date

____ ____________
Signature of guardian/parent (if client is under 18) Date

Video Sessions

Video sessions are utilized to engage in regular counseling sessions for the purpose of distance counseling, only if necessary, with my clients already under contract for counseling services. **Many insurance companies are now supporting such distance sessions. Please contact your insurance plan if you wish to bill for this type of session.** I do offer a cash pay discount for these sessions if you'd prefer to not use insurance.

Gifts

It is my professional practice **to not accept gifts.** I realize that during challenging personal work along with the gains of healing and wellbeing there are deep feelings of gratitude for the opportunity to do this work within a safe and caring environment. If you are called to gift out of gratitude please donate time or items to meaningful worthy people, events and places. Thank you!

Fee Structure and Payment

Fees for Counseling and Consulting:

Free:	15 minute initial consultation to learn about counseling services & fees (phone or in person)
$120.00	per **50 minute** individual client session
$140.00	per 60 minute individual client session
$150.00	per **80 minut**e Individual or Family session

If you choose to pay cash at time of session and not use insurance, I can provide a discounted rate for you.

$ 20.00	per **90-120 minute** Diabetes Support Group
$ 120.00	per hour writing letters, reviewing records or conferring with other professionals as requested by client (billed in 15 min increments.)
$30.00	per 15 minutes spent on phone or email communication outside of clinical session
$100.00	per 50 minute phone session
$120.00	per 50 minute hour preparing release of records per client request or court subpoena

We have agreed upon as session fee or co-pay amount per session:

__________ ____________________________________ _______

Amount Signature Date

Payment responsibility

Payment (or co-payment) is due in full at the time of services. Payment accepted as check, cash or card; receipt can be provided. Missing more than two payments without making a payment arrangement can result in a referral and termination of counseling services.

Reminder of Cancellation Policy - Missed appointments or late cancel with no emergency or illness warrants a $50.00 fee.

Insurance Reimbursement

I am currently an in-network provider with:

- Providence
- Regence- Blue Cross/Blue Shield
- United Behavioral Health
- United Health Care

- Lifewise
- PacificSource
- ***If you would like to use your insurance coverage, please contact your insurance provider directly to verify benefits. It is incumbent on the client to confirm benefits prior to the first session. It is also essential that you update me if your insurance coverage changes.***

Some insurance companies provide coverage for **"out of network"** mental health services. Clients should contact their insurance company to gain knowledge of, or permission for "out of network" counseling services. I will supply an official billing statement of paid fees as well as other required information including a "diagnosis." Clients may then submit this for reimbursement to their insurance company.

By signing below am confirming my understanding of the contents of the informed consent as well as agreeing to expectations and terms defined in the consent. This is considered an agreement to enter into a contract of fee payment for counseling services as described above.

By signing below I am confirming

- I have received a copy of therapist's Professional Disclosure statement as required by state law in relation to Licensed Professional Counselor Licensure
- I have been explained my limits of confidentiality
- We have discussed payment policy and agreed upon a method of payment as well agreement to pay counseling fees.
- I understand the documents and structure of the counseling agreement and have asked for any clarification regarding these documents

Counseling is for: ____
(Client Name/s)

______________________________ ____________
Client signature date

______________________________ ____________
Client signature date

______________________________ ____________
Heather Nielsen, MA, LPC date