BRIDGEWAY
PROFESSIONAL GROUP, LLC

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THERAPY POLICIES & INFORMED CONSENT STATEMENT

Please read this information carefully and let me know if you have any questions or concerns.

PROFESSIONAL CREDENTIALS: I have a Doctorate Degree and I am a Licensed Psychologist in the State of Oregon.

OFFICE HOURS: All office visits are by appointment only and are scheduled by me. Sessions are 45-50 minutes in length. Voice Mail is available 24 hours/day to take messages. If your call is an emergency, please call 287-7006, press "0" at the prompt and an answering service operator will do their best to contact me quickly. When I am out of town, another therapist will be covering for me, and the answering service will have this information.

CANCELLATIONS: When you make an appointment, please try to keep it. If you are unable to keep your scheduled appointment, please call and leave a message stating the reason you are canceling. Cancellations need to be made at least 24 hours in advance or you will be charged for the reserved appointment time. Your health insurance will NOT pay for appointments you fail to keep. You will be personally responsible to pay out of pocket for the full session fee.

CONFIDENTIALITY: Discussions occurring in psychotherapy are confidential or privileged communication. It is important to note that it is the client who holds the privilege. I cannot discuss your case with anyone else without your written permission.

Legal exceptions to confidentiality include:

(1) when a client is a danger to themselves or others;
(2) when there is reason to believe that a minor or elderly person was a victim of a crime, neglect, or sexual / physical abuse;
(3) when ordered by a judge to release information;
(4) when necessary to pursue non-payment of your bill for services rendered;
(5) when a client initiates legal action or makes a complaint against the therapist.

When the client is a minor child, other conditions such as divorce proceedings, lawsuits or other legal matters between the parents may affect confidentiality.

CLIENT'S RIGHTS & RESPONSIBILITIES: Psychotherapy has both benefits and risks. It requires an investment of your time and energy in order to make the process of therapy most successful. Occasionally individuals may go through periods of therapy which may result in emotional discomfort, changes in their relationships, or temporary worsening of their symptoms. This should subside as the work progresses. Remember, you always retain the right to request changes in treatment, to end treatment at any time, or to request a referral to another therapist.

HEALTH INSURANCE: If you are using a health insurance benefit to pay for these services, you need to be aware of what this may mean. Most insurance companies require specific clinical information about you in order to authorize and/or pay for treatment. Health insurance companies usually limit mental health coverage to:

- Services which are considered "medically necessary." This typically means that there is evidence of a diagnosable condition with acute symptoms.
- Conditions that are treatable by short-term, problem-focused, or goal-oriented approaches whenever possible.

This means your insurance company may only cover a limited number of sessions to address a specific diagnosis or problem. Furthermore, a utilization review / quality assurance group set by the insurance company or a peer consultation group may review your case or file. In such a situation, your name and identifying information will be kept confidential.

FEES AGREEMENT: I agree to pay the following fees:

Service	Fee
Initial Session (Diagnostic Interview) 45-50 minutes	$200 per session
Psychotherapy 25-30 minutes	$100 per session
Psychotherapy 45-50 minutes	$150 per session
Couples/Family therapy	$150 per session
Group Therapy	$ 65 per session
Extended phone conversations	$150 per hour (prorated)
Hospital Visits	$150 per hour
Court Testifying Charge for testifying, travel and waiting	$200 per hour
Collateral Contacts	$150 per hour
Report Preparation/Review of Records	$150 per hour

I understand that payment of my fee or co-payment is due and payable at the time of each counseling session, unless otherwise arranged.

I agree to pay the full fee as stated above for missed appointments or appointments cancelled with less than 24 hours notice.

PAYMENT PLAN: [To be completed with your therapist]

[ ] Payment of full fee at time of each appointment

[ ] Client's co-payment of $_____ due at time of each appointment

[ ] Other: _____
_____

RELEASE OF INFORMATION

I authorize the release of my/our clinical record information to my/our insurance company for the purpose of billing, authorization of treatment, healthcare credentialing, utilization review and quality assurance review.

_____ (Signature)
I authorize release of any information necessary to process my insurance claim.

_____ (Signature)
I authorize payment of medical benefits directly to the providers of services.

I have read and understood the agreement, and agree to assume responsibility for the fees incurred in the provision of professional services.

CLIENT OR GUARDIAN

1)_____ Date _____

2)_____

3)_____ _____
THERAPIST

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