HEATHER A. BACON, PH.D., LLC

LICENSED CLINICAL PSYCHOLOGIST

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INFORMED CONSENT TO TREAT

Heather A. Bacon, Ph.D. is a clinical psychologist licensed by the Oregon Board of Psychologist Examiners and is a member of the American Psychological Association and Oregon Psychological Association. Psychological services; psychological evaluations of adults and children, individual and family psychotherapy, and school consultation for positive behavior support plans. Office hours are Monday-Friday 8:00 AM-4:30 PM with the exceptions during holiday, trainings, or illness.

CONFIDENTIALITY: Information that you share in treatment is confidential. This information will not be disclosed in the course of treatment or evaluation, **with the following exceptions**:

1. Information that you pose a "danger" to yourself or others.
2. In cases of suspected abuse.
3. Information that would assist others treating you for medical emergency.
4. Information about treatment of minor children may in some cases be disclosed to their parents.
5. Info compelled by law to disclose information to the courts (i.e. workers compensation, subpoena).
6. Information necessary for your insurance company to process your claim.
7. Other treating physicians.

In the course of therapy information may be requested about you from your referring physician, other professionals or wish to communicate with these persons about your treatments. In an attempt to maintain confidentiality, audio or visual recordings of sessions are not permitted. Please ask me directly if you have questions about particular issues of confidentiality.

TREATMENT OF MINORS: Children of divorced or separated parents under the following conditions (unless otherwise ordered by court):

1. The legal custodial parent must sign the Informed Consent prior to the initiation of treatment.
2. Consultation with the non-custodial parent will occur as needed.
3. Non-custodial parents may bring the child to appointments and provide and receive updates of the child's behavior.
4. Appointments made by the legal custodian for a child during the child's visitation times with non-custodial parent should be arranged with the non-custodial parent's informed consent.
    a. Information that is provided by either parent may be documented in the child's chart. In most cases both parents will have the right to access the child's chart.

FAMILY COUNSELING: When providing services to the family, all participants sign the informed consent documents. There are no off the record discussions; anything you said may be disclosed to other participants. All participants are asked to keep information that is disclosed in sessions confidential. In order to release records, a signed authorization from all participants is required.

APPOINTMENTS: Sessions are made by appointment only. Occasionally an appointment may be cancelled due to emergencies. Please keep our office informed as to how you may be reached in case it is necessary to change you appointment. If you would like to receive courtesy appointment reminder calls **or** text messages sent to your phone please initial: _____

LATE CANCELLATIONS/NO SHOW: Missed or late cancelled appointments without a 24 hour previous business day notice may be billed at the rates listed below. For Monday appointments the notification needs to be given on or before previous business day. You will be responsible for paying the fee for late or missed appointments and insurance will not be billed. The fee will be added to your next billing statement.

Fees for missed or late cancel (with exception to legal consultation-See FEES FOR LEGAL PROCEEDINGS):

First – A discussion of late cancel/no show policy.
Second – Full fee of $215 to be paid by the patient.
Subsequent late cancels/no shows may result in termination of services.

TELEPHONE CALLS: Calls can be made during office hours, but therapy sessions will only be interrupted in case of emergency. All other calls will be returned as soon as possible. You are welcome to leave a brief and confidential phone message after regular office hours. You will be responsible for any extended clinical related telephone conversations that are not billable through insurance. Charges for such phone calls will be prorated-basis.

EMAIL COMMUNICATION: Due to security and privacy concerns Dr. Bacon does not communicate via email. You may choose to provide updates through email if you are unable to attend therapy with your child, this will be at your discretion. However, please be advised this communication may not be secure. This information may not be viewed immediately and should not be used for emergency purposes.

PSYCHIATRIC EMERGENCIES: For emergencies please go to the nearest hospital emergency room or call 911. You may also contact Umatilla County Crisis (866) – 343-4473.

MEDICATIONS: Dr. Bacon does not prescribe medications. If you are already taking psychotropic medications, Dr. Bacon will usually consult with your physician about you response to the medication and its effect on treatment. If Dr. Bacon determines that such medication may be helpful to you, she will refer you to a prescribing provider.

FEES: Are based upon an hour session at a $215 rate, the intake appointment at $322.50. Shorter sessions will be charged on a prorated basis. Telephone calls, report preparation, copying, and sending records are additional services that may be charged separately and are not covered by insurance. If you are unable to pay the rate, a sliding fee scale is available for use in negotiating your fee. You are responsible for payment for all fees that are not covered by insurance. ALL RETURNED CHECKS ARE SUBJECT TO A FEE OF $25.00.

FEES FOR LEGAL PROCEEDINGS: Psychological Assessment, Testimony, Reports, Declarations, Letters and General Consultation (this includes preparation time, office visits, travel, reports, letters, attorney contact, and waiting time) will be charged at a rate of $320.00 per hour. Requests for testimony or consultation that are canceled without 72 hours prior notice will be charged at the above mentioned hourly rate. You are responsible for payment for all fees as we do not bill these services to your insurance company.

BILLING & INSURANCE POLICY: Many health insurance carriers and their managed care companies require preauthorization for your first visit. Our office will attempt to obtain this preauthorization with your help before the first visit. Most insurances plans do not cover 100% of treatment costs. Under a traditional fee-for-service plan you will be responsible for any deductible amount and the percentage of each visit not covered by your plan. Under other insurance plans you are responsible for a co-payment. The exact amount of your payment depends upon your insurance plan. Our staff will assist you in determining what your estimated financial obligations are. You will need to bring your portion of payment to each session.
Upon hardship, please contact the office to discuss payment plan options. Sliding Fee Schedules may be available upon request but are on a limited basis. Applications are available at the front desk.
You will receive a monthly statement informing you of charges accrued for the month and a cumulative balance on your account. In cases where the agreed upon payment plan is not being followed, the account will be turned over to a collection agency. Please contact the office if you have questions about your account.

WHAT TO EXPECT FROM TREATMENT: While many people benefit from therapy, specific results are not guaranteed. Risks include experiencing strong emotion, disappointment in outcomes, and continued distress. Much of your progress will depend on your effort and follow through. Treatment is not limited to time you spend in the office, and may include "homework assignments" to work on between sessions. There may also be times when you wish to have a second opinion about your treatment from another professional, or when consultation with another professional is needed about your case. Please discuss outside consultations with Dr. Bacon. In the event that you wish to terminate treatment and seek services elsewhere, the office can provide you referral information to other professionals.

NONDISCRIMINATION POLICY: The office provides treatment at all individuals seeking services, regardless of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, disability, level of education, political affiliation, source of income, or place of residence or business. A more detailed copy of this policy is available upon request.

GRIEVANCES: We encourage any grievance about treatment or office procedures to be shared directly with the doctor. Unresolved grievances may be taken to the Oregon Board of Psychologist Examiners, (503) 378-4154.

CONSENT TO TREAT

I have read the above Informed Consent and agree to treatment/evaluation under the conditions described above. I acknowledge that I am financially responsible for all agreed upon charges whether or not they are covered by insurance.

Please ask any questions you may have before signing this agreement.

Signature _____ Date: _____